TRICARE Standard Handbook

REVISED DRAFT—May 19, 2000

FOR YOUR RECORDS

Health Care Finder's Name _____
Phone _____

Health Benefits Adviser's Name _____
Phone _____

Beneficiary Counseling & Asst. Coord.'s Name _____
_____ Phone_____

Primary Care Mgr.'s Name _____
Phone _____

Your Military Sponsor's SSN _____
Phone _____

Military Health Care Facility _____
Appointments/phone _____
Emergencies/phone _____
Military medical facility beneficiary advocate name/phone_____

_____
__
Military Lead Agent beneficiary advocate name/phone_____

_____
__

TRICARE Contractor's Name _____
Address _____
Toll-free phone_____
Health Care Finder_____
Claims Processor & Toll-free Phone_____
Nurse Advice Line_____

Primary/Supplemental Insurance Company
_____
Policy No. _____

General Information

Address _____

Phone _____

Emergency Numbers _____

Ambulance Number_____

Poison Control Number _____

Before You Go Any Further...

- If you're planning to get civilian health care under TRICARE (which includes TRICARE Standard, formerly known as CHAMPUS)—do you need a **nonavailability statement**? (See the handbook section on "Where to Get Care" for details.)

- Before you file a TRICARE claim (or have one filed on your behalf by a provider of care)—if you have other health plan coverage (including HMOs or other liability insurance, such as auto, home, etc.) in addition to your TRICARE benefits, you usually must file with that insurance plan first. (See the section on "How to File a Claim" for details.)

  Remember:

  TRICARE doesn't decide who's eligible for uniformed services health care benefits. That's done by each service branch. Eligibility records are kept in the DEERS computer files. DEERS is the Defense Enrollment Eligibility Reporting System. All active and retired military members are listed automatically, but they must take action to list or delete their family members. They must also notify DEERS of all changes, such as marriages, divorces, adoptions, changes of address, etc. (See the end of the "Who's Covered?" chapter for more information about DEERS, including toll-free telephone numbers for the DEERS office where records are kept in Monterey, Calif.)

- Many changes have taken place in the military health care system in the past several years. Changes are still happening. The most important of these changes was the

transition to the Defense Department's TRICARE health care program. TRICARE offers a choice of three health care options: TRICARE Prime (a health maintenance organization (HMO)-type system in which you enroll); TRICARE Extra (a network of providers which you may use on a case-by-case basis at a discounted cost-share); and TRICARE Standard (formerly CHAMPUS), in which you see the authorized health care provider of your choice, then file a claim—or the provider does it for you—for reimbursement by the regional TRICARE contractor).

- Read more about TRICARE's two additional options in the first chapter of this book, which briefly discusses TRICARE Prime and TRICARE Extra.
- Some changes may have taken place in TRICARE since early 2000, when this book was completed. The best way to keep up with these changes, or to get more information about the program, is to talk to your nearest Health Benefits Adviser (HBA), Health Care Finder (HCF), Beneficiary Counseling and Assistance Coordinator (BCAC), or TRICARE Service Center (TSC).

It's important to talk to your HBA at the nearest military hospital or clinic, to your nearest BCAC, to the people at your TRICARE Service Center, or to your Primary Care Manager (if you're enrolled in TRICARE Prime) ***before*** you try to get care from either a military or civilian source.

How to Use This Handbook

Will you be using the TRICARE Standard (formerly CHAMPUS) health care option? This handbook tells you how. It also has information, in the first chapter, about the other two TRICARE options: TRICARE Prime and TRICARE Extra.

Check out the table of contents first. It directs you to the right sections for the answers to your questions about various aspects of the three TRICARE options. If you don't understand the meaning of a particular word or term, check the glossary in the back of the book. Terms and words that have a special meaning under TRICARE are explained there. If you can't find what you want in the table of contents, check the index, which is in the back of the book.

This handbook deals primarily with care received in the United States. Overseas procedures may differ slightly. When that's true, it will be so indicated. Check with your local overseas Health Benefits Adviser, TRICARE Service Center, Health Care Finder, or Beneficiary Counseling and Assistance Coordinator if you have questions.

Remember, ***this handbook does not cover all of the details and special rules of TRICARE*** (the space limitations of publications such as this one don't permit full discussions or explanations of all TRICARE issues or benefits). And, certain rules may change over time. That's why your HBA, BCAC, HCF and TSC are so important. Their job is to help you use your health benefits through uniformed service hospitals and clinics, and through TRICARE. To get in touch with your nearest HBA, BCAC, HCF or TSC, call the information number at the local military base or hospital. If you don't know what hospitals or clinics are located near you, check the back of

this book for a list of medical facilities by state, region or country.

Another excellent source of TRICARE information is the Military Health System/TRICARE Web site and its related links, including links to the various TRICARE contractors. The Web site is at: **www.tricare.osd.mil**

Some Words of Advice

Just because your civilian or military doctor tells you that you need certain care doesn't mean that TRICARE can help pay for it. If you aren't sure whether TRICARE covers a service or supply, contact your HBA, BCAC, HCF, TSC or your TRICARE contractor. *They can advise you about covered services, but they can't guarantee payment by TRICARE.* That determination comes later, after a claim has been submitted. If you're enrolled in TRICARE Prime (the HMO-type TRICARE option), be sure to see your Primary Care Manager (PCM) for a referral before getting any type of specialized medical care. After the PCM makes a referral, the HCF issues an authorization for the care. Your PCM usually contacts the HCF for the authorization, but you should ask the HCF for help in locating a provider and making an appointment.

Also, remember that you, not TRICARE, are receiving the care, and you are responsible for making sure that payment is made for the services you receive.

And don't forget—if you have other medical insurance, you or your health care provider must first file a claim with that insurance plan (unless it's a policy that's designated as a TRICARE supplement) and receive a payment determination before filing with TRICARE.

Keep in mind that the applicable federal law and **32 CFR (Code of Federal Regulations) 199** are the final word on any issue. If there is any difference between this handbook, what anybody tells you, and the law and regulation, it's the law and regulation that apply legally. 32 CFR is on the Military Health System/TRICARE Web site at **www.tricare.osd.mil**. Click on "TRICARE Beneficiaries," then on "TRICARE Manuals."

You Can Make a Difference

Fraud happens when a person or organization deliberately deceives others in order to gain some sort of unauthorized benefit. TRICARE fraud generally involves billing for services that were never rendered, or billing for a service at a higher rate than is actually justified. Health care abuse occurs when providers supply services or products that are medically unnecessary, or that do not meet professional standards.

Fraud and abuse drive up health care costs. Review your bills and Explanation of Benefits (EOB) forms carefully for any discrepancies (for example, there are charges on the bill for services you didn't receive, or the person identified on the bill as providing the care isn't the one who gave you the care). Notify your TRICARE contractor immediately, using the toll-free telephone number that's on the EOB. You can make a difference in fighting health care fraud and abuse. (See the end of the "Tips on Using TRICARE Standard" chapter for more information.)

TRICARE Information On-Line

You can find this handbook—as well as other information about TRICARE—on the Military Health System/TRICARE Web site.

The address is **www.tricare.osd.mil**.

We welcome any suggestions you may have to improve this handbook. Please send your suggestions to the TRICARE Management Activity, Office of Communications and Customer Service, Skyline Five, Suite 810, 5111 Leesburg Pike, Falls Church, VA 22041-3206.

Table of Contents

A Look at TRICARE

TRICARE: What Is It?

TRICARE is the name of the Defense Department's regional managed health care program for service families. Under TRICARE, you'll generally have three options for health care:

- TRICARE Prime
- TRICARE Extra
- TRICARE Standard (formerly called CHAMPUS)

Here's a brief look at each of the three options:

TRICARE Prime

This is a voluntary health maintenance organization (HMO)-type option. If you decide to get your health care through TRICARE Prime, you'll pay an annual enrollment fee (except for active duty members and their families, who may enroll free) and enroll for a continuous period of time. You'll stay enrolled until you decide to disenroll, or until you're no longer eligible for TRICARE Prime.

Also, you can pay one enrollment fee and "split" your family's enrollment—that is, you can have different family

members enrolled in Prime in different TRICARE regions, at no additional cost.

Your TRICARE Prime enrollment is "portable"—you can take it with you if you move from one TRICARE region to another, without having to disenroll in one region and reenroll in another. Check with your TRICARE Service Center for information about how to do this, and on what the limitations are.

Normally, you'll receive your care from within the Prime network of civilian and military providers.

You'll either choose or be assigned a Primary Care Manager (PCM) from within the contractor's network or at your nearest uniformed services medical facility, who will furnish most of your care and will manage all aspects of your care, including referrals to specialists. The Health Care Finder (HCF), available through regional contractors' toll-free phone numbers, assists you and your PCM in finding the appropriate specialty care for you.

Covered services will be like those of regular CHAMPUS (now known as TRICARE Standard), plus additional services that aren't covered under TRICARE Standard or TRICARE Extra.

Is TRICARE Prime the Right Plan For You?

It depends. On the one hand, TRICARE Prime may be the least costly of the three TRICARE options for you. You'll be able to predict your health care costs more exactly. As noted earlier, there's no enrollment fee for active duty members and

their families—just modest co-payments when you get health care within the Prime network of civilian providers.

Prime is easy to use. You'll have a Primary Care Manager (PCM) at your military medical facility or in the Prime provider network, from whom you'll get most of your care, and who will refer you to specialists within the network when necessary. Your local Health Care Finder (HCF) at the TRICARE Service Center (TSC) will make the arrangements for you to get the specialized care after you receive a referral from your PCM.

The services of Health Care Finders are available to you 24 hours a day, seven days a week. The various TRICARE Service Centers in the region served by your contractor will have representatives available during regular business hours to provide information about all aspects of your health benefits.

There's less paperwork with Prime. When you get care from a provider who's part of the Prime network, you don't have to file claims (but if you should seek care from a non-network provider, you or the provider may have to file a claim with the regional TRICARE contractor).

TRICARE Prime may not be your best bet if you have other health insurance that's your primary coverage (this is especially true if the other health insurance is an HMO, since the other health insurance and TRICARE Prime may require that you use different providers). In such a case, Prime will only pay ***after*** your other insurance has paid whatever it's going to pay for your civilian care. ***If you discontinue your other health insurance when you enroll in Prime, and later become ineligible for Prime, you might have difficulty getting your other insurance back, or you might experience some waiting periods, if you have any pre-existing medical conditions.***

If you travel out of your TRICARE Prime service area very often, Prime might not be your best choice. The reason: When you get civilian care outside your TRICARE Prime service area, Prime will only pay for emergency services—and for urgent care when it has been authorized in advance by the Health Care Finder in your home service area.

You might not want to enroll in TRICARE Prime if you don't want to be restricted to using only providers who are members of the Prime network. A better choice might be either the TRICARE Extra or TRICARE Standard options, which are described later in this chapter.

When you enroll in TRICARE Prime, your enrollment is continuous. During the period of your enrollment, you're "locked in" to using only Prime (with the expensive exception of getting care under the "point-of-service" option—more about that later in this chapter) unless you become ineligible for TRICARE while enrolled, or unless you move from your local TRICARE Prime service area to a non-Prime area and have to disenroll from Prime as a result.

Note:

There are no pre-existing condition limitations for enrollment in TRICARE Prime¾ or for use of the other two TRICARE health care options, Extra and Standard.

TRICARE Extra

With this option, you don't have to enroll or pay an annual fee. You do have to satisfy an annual deductible for outpatient

care, just as you do under TRICARE Standard. (See the section on TRICARE Standard below, and also see the chapter titled "How Much Will It Cost?" for more information about the deductible under TRICARE Standard.) The deductible and cost-sharing work the same way under TRICARE Extra.

On a visit-by-visit basis, you can seek care from a provider who's part of the TRICARE Extra network, get a discount on services, and have reduced cost-shares—five percent less than under TRICARE Standard. Also, you generally won't have to file any claim forms. You pay annual deductibles for outpatient care before government cost-sharing starts, as you do under TRICARE Standard. You can get a list of the TRICARE Extra providers by contacting one of the TRICARE service centers located in your region, by calling the toll-free number established by the TRICARE contractor, or by checking a contractor's Web site.

TRICARE Standard

This option is the former CHAMPUS program with a new name. It pays a share of the cost of covered health care services that you obtain from an authorized non-network civilian health care provider. There's no enrollment in TRICARE Standard. You'll pay the normal TRICARE Standard deductibles for outpatient care, and your cost-sharing percentages will be the same as they were for regular CHAMPUS.

TRICARE is in Your Area Now

The TRICARE program is now in operation worldwide. *However, TRICARE Prime and TRICARE Extra may not be*

available in all parts of the country, if a TRICARE contractor does not have a network of providers in a particular area. If that's the case where you live, you can still use TRICARE Standard.

Listed below are the various Department of Defense Health Service Regions, beginning with the first region in which TRICARE was implemented. (Note: You can reach the Web site for a particular TRICARE region's contractor—and for the military lead agent for each region—through links that are available by going to the Department of Defense's Military Health System/TRICARE Web site at: **www.tricare.osd.mil**.

Region 11 (Northwest)—(Washington, Oregon, plus the following six counties in northern Idaho: Benewah, Bonner, Boundary, Kootenai, Latah and Shoshone). Began March 1, 1995.

Contractor: Foundation Health Federal Services. Toll-free phone: 1-800-404-0110.

Regions 9 (Southern California) and 10 (Golden Gate)—(California and the Yuma, Ariz. area). ***Except*** for Yuma (Yuma's inclusion in Region 9 began April 1, 1997), TRICARE operations began Oct. 1, 1995 (had an early form of TRICARE for several years before that).

Contractor: Foundation Health Federal Services. Toll-free phone: 1-800-242-6788.

Region 6 (Southwest)—(Oklahoma, Arkansas—***except*** for a small piece of northeastern Arkansas that's in the Naval Hospital, Millington, Tenn., service area—most of Texas ***except*** for a triangular piece of the southwestern part of the state that

includes El Paso, and approximately the western two-thirds of Louisiana, generally west of Baton Rouge). Began Nov. 1, 1995.

Contractor: Foundation Health Federal Services. Toll-free phone: 1-800-406-2832.

Regions 3 (Southeast) and 4 (Gulf South)—(Florida, Georgia, South Carolina, Alabama, Tennessee, Mississippi, the eastern third of Louisiana, which includes New Orleans and Baton Rouge, and a small part of northeastern Arkansas that's in the Naval Hospital, Millington, Tenn. service area). Began July 1, 1996.

Contractor: Humana Military Healthcare Services. Toll-free phone: 1-800-444-5445 (Beneficiary Services); 1-800-333-4040 (Health Care Finder); 1-800-403-3950 (Routine Claims).

Central Region (formerly known as Regions 7 and 8)—(Arizona, Nevada, New Mexico, Colorado, Wyoming, Utah, most of Idaho, Montana, North and South Dakota, Kansas, Nebraska, Minnesota, Iowa, that piece of southwestern Texas which includes El Paso, and Missouri—***except*** for the St. Louis area). Began April 1, 1997.

Contractor: TriWest Healthcare Alliance. Toll-free phone: 1-888-874-9378.

Region 2 (North Carolina and most of Virginia, ***except*** a small part of northern Virginia). Began May 1, 1998.

Contractor: Anthem Alliance for Health, Inc. Toll-free phone: 1-800-931-9501.

Region 5 (Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, a small part of Tennessee, the St. Louis area in Missouri, and most of West Virginia, ***except*** for a small section of the eastern part of the state that's included in Region 1). Began May 1, 1998.

Contractor: Anthem Alliance for Health, Inc. Toll-free phone: 1-800-941-4501.

Region 1 (Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, the District of Columbia, certain northern Virginia ZIP codes located near the Washington, D.C., area, and a few ZIP codes in northeastern West Virginia). Began June 1, 1998.

Contractor: Sierra Military Health Services, Inc. Toll-free phone: 1-888-999-5195.

TRICARE Pacific (Alaska, Hawaii, Western Pacific).

Toll-free phone: 1-800-242-6788.

TRICARE Europe (Europe, Africa, Middle East, Azores and Iceland).

Toll-free phone: 1-888-777-8343.

TRICARE Latin America (Panama, Central and South America, Puerto Rico, Virgin Islands).

Puerto Rico and Virgin Islands toll-free phone: 1-800-444-5445. Toll-free phone for all others: 1-888-777-8343.

TRICARE Overseas (includes areas outside the U.S., as listed previously). TRICARE Prime and TRICARE Standard

are offered to service families overseas. Networks of providers for the Prime health care option are developed by local military medical facilities in overseas areas. (See details about TRICARE overseas at the end of this chapter.)

Who's Eligible For TRICARE?

In order to use TRICARE, you must be listed in the Defense Department's DEERS (Defense Enrollment Eligibility Reporting System) computerized database as being eligible for military health care benefits. (For more details about DEERS, see the "Who's Covered?" section.)

TRICARE-eligible persons include: eligible family members of active duty service members; military retirees and their eligible family members; surviving eligible family members of deceased active or retired service members; Medicare-eligible retirees who are under age 65 and are enrolled in Medicare Part B; wards and pre-adoptive children; and some former spouses of active or retired service members who meet certain length-of-marriage rules and other requirements. (See the "Who's Covered" chapter for more details.)

Also eligible are certain family members of active duty service members who were court-martialed and separated for spouse or child abuse; certain abused spouses, former spouses, or dependent children of service members who were retirement-eligible but lost that eligibility as a result of abuse of the spouse or child; and spouses and children of North Atlantic Treaty Organization (NATO) and "Partners for Peace" (PFP) nation representatives. (NATO and PFP family members aren't eligible to enroll in TRICARE Prime.) Check with your Health

Benefits Adviser, Beneficiary Counseling and Assistance Coordinator, or TRICARE Service Center for details.

In order to use TRICARE Prime, you must live in an area where a civilian provider network has been established to support the program.

Who's *Not* Eligible For TRICARE?

1. Most persons who are eligible for Medicare because of age (except active duty family members). People who are Medicare-eligible because of disability or end-stage renal disease, and are under 65, may retain TRICARE eligibility until they reach age 65, but they must be enrolled in Medicare Part B.
2. Persons who are eligible for benefits under CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs).

What Will TRICARE Cost?

TRICARE is designed to be a uniform benefit, and features a fee structure that will be the same for most people in all parts of the country. On these next two pages are tables showing some of the costs associated with the three TRICARE options.

TRICARE Costs

The tables on the next pages provide examples of cost-shares or co-payments for families who use civilian providers and facilities under each of the three TRICARE options. The

listed fees are subject to change. The pages following these tables contain more information on costs.

Active Duty Family Members:

	TRICARE Prime E-1—E-4	TRICARE Prime E-5 & up	TRICARE Extra	TRICARE Standard
Annual Deductible	None	None	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below
Civilian Outpatient Visit	$6/visit	$12/visit	15% of negotiated fee	20% of allowable charge
Civilian Inpatient Admission	$11/day ($25 minimum)	$11/day ($25 minimum)	Greater of $25 or $10.85/day	Greater of $25 or $10.85/day
Civilian Inpatient Mental Health	$20/day	$20/day	$20/day	$20/day

Retirees, Their Family Members, and Others:

	TRICARE Prime	TRICARE Extra	TRICARE Standard (CHAMPUS)
Annual Deductible	None	$150/individual or $300/family	$150/individual or $300/family
Annual Enrollment Fees	$230/individual $460/family	None	None
Civilian Provider Co-Pays:		20% of negotiated fees	25% of allowed charges
Outpatient Visit	$12		
Emergency Care	$30		
Mental Health Visit	$25 ($17 for group visit)		
Civilian Inpatient Cost-Share	$11/day ($25 minimum) charge per admission	Lesser of $250/day or 25% of negotiated charges plus 20% of negotiated professional fees	Lesser of $390/day or 25% of billed charges plus 25% of allowed professional fees
Civilian Inpatient Mental Health	$40/day	20% of institutional & negotiated professional charges	Lesser of $144/day or 25% of institutional & professional charges

Point-of-Service

If you're a TRICARE Prime enrollee, you also have what's called a "***point-of-service*" *(POS) option***. This means that you can choose to get TRICARE-covered non-emergency services outside the Prime network of providers without a referral from your Primary Care Manager and without authorization from a Health Care Finder (HCF). However, if you choose to get care under the POS option, there's an annual deductible (for both inpatient and outpatient care) of **$300** for an individual and **$600** for a family. After the deductible is satisfied, your cost-share will be **50 percent** of the TRICARE allowable charge. Any additional charges by non-network providers are also your responsibility: up to 15 percent above the allowable charge, as permitted by law. POS cost-sharing may also apply to services you receive from a Prime network provider if you don't get the required advance authorization for the care.

Because of the increased costs associated with point-of-service care, you should always contact your Primary Care Manager (PCM) and Health Care Finder (HCF) to get authorization ***before*** getting care. Be sure to get (and keep for your records) an authorization number, documenting the fact that you received the authorization to get the care.

The POS option does not apply to TRICARE Extra or TRICARE Standard.

Catastrophic Cap

There's an upper limit, or "catastrophic cap," on what you'll have to pay for health care under TRICARE Prime, for Prime enrollment fees, inpatient and outpatient cost-shares, and

co-payments for such things as visits to the doctor (there's also a cap on expenses under TRICARE Extra and TRICARE Standard; see the "How Much Will It Cost?" chapter for details). For active duty families enrolled in Prime, it's $1,000 per fiscal year (Oct. 1 through the following Sept. 30); for all other Prime enrollees, it's $3,000 per enrollment year, ***unless*** you get care on your own ***without*** a referral from your TRICARE Prime PCM and ***without*** an authorization from the HCF (this is called using the "point-of-service," or "POS" option, which is explained above). If you do that, your POS medical expenses will not be "capped." *For more details about cost caps, check with your HBA/TSC.*

Remember:

The catastrophic cap applies only to allowable charges for covered services. There's no annual cap on charges for services that aren't covered, or on the yearly accumulation of what non-participating providers of care may bill you above the allowable charges for the care you received.

TRICARE Extra

In the TRICARE Extra program, when you receive care from an Extra network provider, you get a discount on cost-sharing, and you don't have to file your own claims. You don't enroll, and may use Extra on a case-by-case basis just by using the network providers.

The annual outpatient deductibles for TRICARE Extra are the same as for TRICARE Standard: for the families of active duty E-4s and below, $50 for one person or $100 for a family

per fiscal year. For all others, the deductible is $150 for one person, or $300 for a family.

In general, after the annual outpatient deductible has been satisfied, the cost-share for care under TRICARE Extra for an active duty family member will be 15 percent of the fee for which the TRICARE Extra network provider has contracted to provide the medical service or supply. All other eligible persons will pay a 20 percent cost-share of the contracted fee.

There are a few exceptions to the Extra cost-sharing percentages. (See the cost charts on previous pages.)

In addition to what's on the charts, the ***ambulatory surgery*** cost is $25 for active duty families and 20 percent of the contracted fee for all others.

There's an annual "catastrophic cap" on how much families will have to pay for their covered care under TRICARE Extra. It's the same as for TRICARE Standard. (See the "How Much Will It Cost?" chapter for details.)

TRICARE Standard (CHAMPUS)

What's now called TRICARE Standard is much like the CHAMPUS program that served military families for more than 30 years. Coverages, deductibles, cost-shares and claim filing rules are the same. Annual outpatient deductibles are the same as for TRICARE Extra. As with Prime and Extra, there's an annual "catastrophic cap" on costs. (See the "How Much Will It Cost?" chapter for more information.)

What Are the Priorities for Care in Military Hospitals?

The policy established by the Assistant Secretary of Defense for Health Affairs in August 1996 created the following priorities for access to health care in uniformed services medical treatment facilities:

1. Active duty service members.
2. Active duty family members ***who are enrolled in TRICARE Prime*** (for the purpose of determining access priority, survivors of military sponsors who died on active duty ***who are enrolled in TRICARE Prime*** are included in this priority group).
3. Retirees, their family members and survivors ***who are enrolled in TRICARE Prime***.
4. Family members of active duty service members ***who are NOT enrolled in TRICARE Prime*** (for the purpose of determining access priority, survivors of military sponsors who died on active duty who are ***not*** enrolled in TRICARE Prime are in this priority group).
5. All other eligible persons.

See the "Where to Get Care" chapter for more details on access to, and priorities for care.

Will TRICARE Exclude Retirees from Military Hospitals?

Eligible retirees, their family members and survivors *who are enrolled in TRICARE Prime* will have improved access to

military hospitals. Those who decide not to enroll in Prime, or those who are not eligible for TRICARE, may find their opportunities for space-available care reduced, because most of the space at military hospitals and clinics will be devoted to TRICARE Prime enrollees.

TRICARE Senior Prime

In 1998, the Defense Department began a three-year demonstration project called "TRICARE Senior Prime" (also known as "Medicare subvention"), at 10 sites throughout the U.S. The project's purpose is to determine whether uniformed services medical facilities can deliver accessible, high-quality care to "dual-eligibles" (persons who are both Medicare-eligible and eligible for care in military medical facilities, who are enrolled in Medicare Part B, and who meet other requirements) at a cost that doesn't increase the total federal cost for such care, for either Medicare or DoD.

The 10 sites, which have enrolled eligible persons in TRICARE Senior Prime on a first-come first-served basis, are:

Madigan Army Medical Center, Fort Lewis, Wash.; Keesler Air Force Base, Biloxi, Miss.; Brooke Army Medical Center, and Wilford Hall Air Force Medical Center, both in San Antonio, Texas; Fort Sill, Lawton, Okla.; Sheppard Air Force Base, Wichita Falls, Texas; Fort Carson and the Air Force Academy, both in the Colorado Springs, Colo., area; Naval Medical Center, San Diego, Calif.; and Dover Air Force Base, Dover, Del.

Persons who have enrolled in TRICARE Senior Prime at any of the 10 test sites have access to all of the benefits of

Medicare, plus the benefits of being enrolled in TRICARE Prime. There isn't any TRICARE Prime enrollment fee, but enrollees will have to continue to pay for Medicare Part B.

The demonstration is scheduled to continue through Dec. 31, 2000. Check the Military Health System/TRICARE Web site at **www.tricare.osd.mil** for more information.

FEHBP Demonstration Program for Retirees

In 2000, the Defense Department began a three-year demonstration program in which up to 66,000 uniformed services retirees and their families in selected areas are eligible to enroll in, and get their health care through, the Federal Employees Health Benefits Program (FEHBP)—the health plan that federal civil service employees use.

In order to enroll in one of the participating FEHBP health plans, retired sponsors and their families must live within the designated ZIP code areas that encompass one of the test sites. The sites are: Dover Air Force Base, Del.; Fort Knox, Ky.; Greensboro/Winston-Salem/High Point, N.C.; Dallas, Texas; New Orleans, La.; Naval Hospital, Camp Pendleton, Calif.; the Humboldt County area (and surrounding counties), Calif.; Coffee County, Ga.; Adair County, Iowa; and Puerto Rico.

The following people are eligible to participate in the demonstration:

- Medicare-eligible military retirees and their family members.
- Family members of deceased active or retired military members.

- Certain un-remarried former spouses of military service members or former members.

Coverage under the demonstration began Jan. 1, 2000. The demonstration is expected to run through Dec. 31, 2002.

PLEASE NOTE: Persons who enroll in the FEHBP demonstration may not use military medical facilities, TRICARE benefits, or pharmacy services during the period of their enrollment.

For more details about the FEHBP test program (eligibility, enrollment, participating plans, etc.), call the Defense Department's Information Processing Center toll-free at 1-877-363-3342. Or, go to the Military Health System/ TRICARE Web site at: **www.tricare.osd.mil/fehbp/**

Pharmacy Redesign Pilot Program

A Defense Department pilot program that began in two U.S. counties in the summer of 2000 makes retail and mail-order pharmacy benefits available to certain military retirees and their family members who are Medicare-eligible, aged 65 and older, and who have enrolled in Medicare Part B.

The pilot program is being operated in Okeechobee County, Fla., and Fleming County, Ky. To be eligible for the program, potential enrollees must live in designated ZIP codes in and around these counties.

Both retail and mail-order prescription services are available in the pilot program, as is the military hospital pharmacy benefit that's already available, regardless of location. There'll

be an enrollment fee and co-payments for drugs purchased through the program.

The pharmacy pilot program is one of several programs being tested by DoD across the country to increase access to health care for retirees (see also the sections on the TRICARE Senior Prime and FEHBP tests, immediately preceding this section). The pharmacy pilot program is intended to help solve the problem of high health care costs for persons who are 65 or older, who don't have easy access to a military hospital, and who don't have a prescription benefit through other insurance.

If you're interested in enrolling in the Pharmacy Redesign Pilot Program, contact your nearest TRICARE Service Center to find out if you live in one of the ZIP code areas covered under the program. You can also find this information on the Military Health System/TRICARE Web site, at **www.tricare.osd.mil**.

For more details, or for enrollment information, call a TRICARE representative at 1-800-444-5445 for the Okeechobee County, Fla., area; or 1-800-941-4501 for the Fleming County, Ky., area.

BRAC Pharmacy Benefit

Despite the closing of three military bases on May 1, 1999, Medicare-eligible beneficiaries and their family members who are Medicare-eligible, who had been using pharmacies at those bases, haven't lost their pharmacy benefits.

The three bases are: Onizuka Air Station, in Sunnyvale, Calif.; Red River Army Depot, in Texarkana, Texas; and Fort McClellan, in Anniston, Ala. They were closed under the

Defense Department's Base Realignment and Closure (BRAC) authority. If you live within the ZIP code service area (also called a "catchment area") around the military hospital that was located at one of the bases, you'll be able to get your medications from TRICARE network retail pharmacies, or from the National Mail Order Pharmacy Program (NMOP).

If you live outside the ZIP code service area of one of the military hospitals on the three closed bases, but you relied on the base pharmacy at least once during the 12 months immediately before its closure, you may be eligible to use the mail-order and retail pharmacy benefits. You must complete a Declaration of Reliance form, which you can get from the Defense Enrollment Eligibility Reporting System (DEERS), by calling toll-free, 1-800-538-9552.

For more information about NMOP, call the contractor, Merck-Medco, toll-free, at 1-800-903-4680. Or, visit the Military Health System/TRICARE Web site at: **www.tricare.osd.mil/tricare/nmopp.html**.

For more information about which local drug store to use in TRICARE's retail network pharmacy program, call the appropriate regional TRICARE contractor's toll-free telephone number, as follows:

For Onizuka Air Station, call 1-800-242-6788.

For Red River Army Depot, call 1-800-406-2832.

For Fort McClellan, call 1-800-444-5445.

TRICARE Prime Remote

This is a new program that's designed to bring the TRICARE Prime benefit to active duty members and their families in any location in the U.S.

Who's eligible? Active duty service members who live and work more than 50 miles from a military hospital or clinic. Wherever possible, active duty family members who are accompanying active duty service members on remote assignments will also have the chance to enroll in TRICARE Prime.

For information on how to enroll and on the benefits of the program, contact the nearest military hospital or TRICARE Service Center. Another excellent source of information on TRICARE Prime Remote (and other TRICARE programs) is the Military Health System/TRICARE Web site, at **www.tricare.osd.mil**.

TRICARE Senior Supplement Demonstration

This test program is for military Medicare-eligible persons who are age 65 and older, and who live within designated ZIP codes in areas around Santa Clara County, Calif., and Cherokee County, Texas. It began April 1, 2000, and is scheduled to end Dec. 31, 2002.

The TRICARE Senior Supplement Demonstration (TSSD) offers affordable coverage that's secondary to Medicare, and includes a pharmacy benefit for those who enroll.

Eligible persons include retired members of the uniformed services, their family members, and surviving family members of deceased uniformed-service members who died while on

active duty for a period of more than 30 consecutive days. Enrollees must also be age 65 or older, eligible for Medicare Part A, enrolled in Medicare Part B, and must live within one of the demonstration sites.

TSSD offers enrollees benefits similar to TRICARE Extra and TRICARE Standard. Benefits include access to the National Mail Order Pharmacy, use of TRICARE civilian network pharmacies, coverage for certain diagnostic and preventive services, extended mental health coverage, and coverage for health care services delivered outside the continental U.S.

The enrollment cost is $576 per person, per year. You may make four quarterly payments of $144 each. Your initial payment must be sent in with your enrollment. You must also satisfy an annual deductible and pay cost-shares for your care.

For more information about the TSSD, call toll-free, 1-877-363-8773, Monday through Friday, from 8 a.m. to 5 p.m., Central Standard Time. Or, go to the Military Health System/TRICARE Web site at: **www.tricare.osd.mil/tssd/**

TRICARE Overseas

Active duty military families who live overseas can choose how to get their health care under TRICARE. They have two options: **TRICARE Prime** and **TRICARE Standard**. Military retirees and their families who live overseas can't enroll in TRICARE Prime, but they can use TRICARE Standard.

Under **TRICARE Prime**, active duty eligible families who live overseas must enroll as they would stateside. Enrollment in

TRICARE Prime for active duty families overseas is not automatic. Military sponsors must take action to enroll their families in Prime. Active duty families will pay no enrollment fees, cost-shares or deductibles while overseas.

Prime enrollees will have access to both military medical facilities and to networks of local civilian providers put together by the commanders of military medical facilities. Wherever possible or available, most of their care will be provided by their Primary Care Manager (PCM) to whom they'll be assigned. When necessary, they'll have access to specialized care recommended by the PCM. Regional military service centers will provide Prime beneficiaries authorization for care not provided by the PCM, upon the PCM's referral.

The extent of provider networks will depend on the area—but even if a network is not available in a given location, enrolled active duty families will still have their cost-shares and deductibles waived when authorized by the regional military service center upon a PCM's referral. However, if an overseas family member who's enrolled in Prime uses a ***non-network*** provider of care ***without getting an advance authorization from the regional military service center***, cost-shares and deductibles will apply. And, they'll be ***point-of-service*** cost-shares and deductibles.

Overseas TRICARE Prime enrollees who receive civilian care while they're traveling back in the U.S. will pay the same co-payments that other Prime enrollees in the U.S. pay. When receiving care in the U.S., they won't need advance authorization for urgent or emergency care.

Overseas Prime enrollees traveling in the U.S. will have the same priority for available appointments at military medical facilities as Prime enrollees who live near these facilities.

Persons who are enrolled in TRICARE Prime overseas may call, toll-free, 1-888-777-8343 for assistance during normal business hours.

TRICARE Standard is available to overseas families who choose not to enroll in Prime. Benefits and procedures are the same as in the U.S. (See the chapter titled "How to File a Claim" for instructions on claim filing and claims mailing addresses.) Information about TRICARE Standard in overseas areas is also available from Health Benefits Advisers at military medical facilities.

* * *

The rest of this handbook is devoted to discussions of the various aspects of using TRICARE Standard. For example, see the chapter called "How Much Will It Cost?" for detailed information about the costs associated with using TRICARE Standard, including a discussion of the "catastrophic cap" on patients' costs for covered care.

Note: If you do decide to enroll in TRICARE Prime, your regional TRICARE contractor will give you a Prime handbook that's specific to the region in which you live. Among your contractor's publications will be a booklet containing information about TRICARE Prime and Extra network providers.

TRICARE Standard in a Nutshell

TRICARE Standard is what for years was called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The name has been changed to TRICARE Standard—one of the three TRICARE options that are available to TRICARE-eligible people now (TRICARE Prime isn't available in some places). The rest of this handbook concentrates on TRICARE Standard.

TRICARE Standard shares most of the costs of care from civilian hospitals and doctors when you can't get care through a military hospital or clinic. But there are certain important things you need to know about TRICARE Standard before using it.

- The most comprehensive and lowest cost medical care is available from military medical facilities.
- Benefits and costs vary for different categories of eligible persons.
- While you may be eligible to use military medical facilities, your access may be restricted based on space availability.
- Some people are not eligible for TRICARE Standard, such as active duty service members, dependent parents and parents-in-law, most children age 23 and older, and most persons who are eligible for Medicare hospitalization

insurance (Part A) because they've turned 65. (See the section called "Who's Covered?" for details.)

- TRICARE Standard **is not free**. You must pay part of your medical costs, as well as everything TRICARE Standard doesn't cover. (See the section called "How Much Will It Cost?" for cost information.)
- TRICARE Standard **does not cover all health care**. There are special rules or limits on certain care, and some care is not covered at all. (See the sections on "What's Covered?" and "What's Not Covered?" for information.)
- TRICARE Standard pays for only medically necessary care and services that are provided at an "appropriate level of care." Claims for services that don't meet this definition will be denied.
- Your physician **must be certified by the regional contractor as an authorized provider of care** under TRICARE Standard for the government to share the cost of care you receive from him/her. Being "authorized" or "certified" is not the same as being a "participating" or "non-participating" provider of care under TRICARE Standard. (See the chapter titled "Where to Get Care" for discussions of authorized providers as well as participation and non-participation.)
- You or your provider **must file claims before TRICARE Standard can pay its share of the bills**. For your sake, it's important to fill out the claim form correctly and to include any necessary paperwork. (See the section on "How to File a Claim" for more information.)

- Equally important, all TRICARE Standard-eligible persons **must be enrolled in the DEERS computerized eligibility database** before TRICARE Standard claims can be paid. (See the last part of the "Who's Covered?" section for more information about DEERS.)

- The section called "Tips on Using TRICARE Standard" has information that will help you use your health benefits. The most important one is to get to know your Health Benefits Adviser (HBA), Beneficiary Counseling and Assistance Coordinator (BCAC), Health Care Finder (HCF), Beneficiary Services Representative (BSR) and others at your nearest military medical facility (MTF) or TRICARE Service Center (TSC). Their job is to help you locate providers and get the medical care you need, at the best price and in the most convenient manner. There are HBAs at many military hospitals and clinics; and TRICARE Service Centers are located throughout the regions served by the various TRICARE contractors. In the back of this handbook, in the section called "Uniformed Services Medical Facilities," there's a list of military hospitals and clinics, by state and country.

One last note: In these times of rising medical costs, it's especially important to use your health benefits only when you really need to (of course, you shouldn't hesitate to use the preventive care and "wellness" benefits that are available to you and your family, for continued good health). Although it may be more difficult in an age of reduced resources and base closures, try to use military hospitals and clinics whenever possible. They save money for you and the government. By using your health benefits wisely, you help make sure the funds will be there when needed.

Who's Covered?

TRICARE Standard is a health benefits program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration. If you don't find answers to your eligibility questions in this chapter, check with your military personnel office for specific information.

Here's a list of who's covered by TRICARE Standard (see details of eligibility, such as age limitations for children, later in this chapter):

- **Husbands, wives and unmarried children of active duty service members.** (See details on the next two pages for eligibility of all unmarried children.)
- **Retirees, their husbands or wives, and unmarried children.**
- **Un-remarried husbands and wives and unmarried children of active duty or retired service members who have died.**

Note:

Family members of active duty service members who died while on active duty, and who were on active duty for at least 30 days before death, will continue to be treated as active duty family members for TRICARE

Standard cost-sharing purposes for one year after their active duty sponsor dies.

- **Husbands, wives and unmarried children of reservists who are ordered to active duty for more than 30 consecutive days (they are covered only during the reservist's active duty tour) or of reservists who die on active duty.**
- **Husbands, wives and unmarried children of reservists who are injured or aggravate an injury, illness or disease during, or on the way to, active duty training for a period of 30 days or less, or a period of inactive duty training, and who die as a result of the specific injuries, illnesses or diseases.**
- **Former spouses of active or retired military who were married to a service member or former member who had performed at least 20 years of creditable service for retirement purposes at the time the divorce or annulment occurred.** The former spouse must also meet the following requirements:

  1. Must not have remarried.
  2. Must not be covered by an employer-sponsored health plan.
  3. Must not be eligible for Part A of Medicare due to age, ***except*** under certain conditions. (See the paragraphs in this section titled "Medicare and TRICARE Standard.")
  4. Must not be the former spouse of a NATO (or "Partners for Peace" nation) member. And—

5. Must meet the requirements of one (not all) of the following three situations:

Situation 1:

Must have been married to the SAME member or former member for at least 20 years, and at least 20 of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment was on or after Feb. 1, 1983, the former spouse is eligible for TRICARE coverage of health care that is received after that date. If the date of the final decree is before Feb. 1, 1983, the former spouse is eligible for TRICARE coverage of health care received on or after Jan. 1, 1985.

Situation 2:

Must have been married to the SAME military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment is ***before April 1, 1985***, the former spouse is eligible only for care received on or after Jan. 1, 1985, or the date of the decree, whichever is later.

Situation 3:

Must have been married to the SAME military member or former member for at least 20 years, and at least 15—but less

than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment is ***on or after Sept. 29, 1988***, the former spouse is eligible only for care received for one year from the date of the decree.

Upon completion of the period of eligibility for TRICARE, explained in Situation 3 above, a former spouse is eligible for the ***Continued Health Care Benefit Program (CHCBP).***

Continued Health Care Benefit Program

CHCBP is intended to provide transitional benefits similar to TRICARE Standard for a specific period of time (18-36 months) to former service members and their family members, some un-remarried former military spouses, and emancipated children (living on their own), who enroll and pay quarterly premiums. The quarterly premiums are $933 for one person and $1,996 for a family. The premiums are based on comparable Federal Employee Health Benefit Program rates paid by employees and their employers, plus an administrative fee of up to 10 percent. Benefits are like those in the basic TRICARE Standard program; however, CHCBP is not part of TRICARE Standard.

Eligible persons must enroll in CHCBP within 60 days after separation from active duty or loss of eligibility for military health care. The Defense Department has chosen a contractor to administer CHCBP, including enrollment and updates of the DEERS database. The contractor will accept applications for enrollment and

checks for the first three months' coverage. The contractor will send a letter of acceptance, which will serve as proof of enrollment when a person seeks care, if they are unable to update DEERS immediately. (See the section at the end of this chapter for more about DEERS.)

You may call the contractor toll-free at 1-800-809-6119 for more information. Or, you may write to: CHCBP Administrator, P.O. Box 1608, Rockville, MD 20849-6119.

Contact your Health Benefits Adviser for more details, and see your military personnel office for eligibility determinations.

- **Unmarried children up to age 21.** Children (including stepchildren ***who are adopted by the sponsor***) are still covered by TRICARE even if the spouse gets divorced or remarried. But in the case of a stepchild who was not adopted by the sponsor and the marriage ends in divorce, the stepchild loses eligibility on the date the divorce decree is final. It should be emphasized that stepchildren don't have to be adopted by the sponsor to be covered by TRICARE while the sponsor and the mother or father of the stepchildren remain married. A child aged 21 or older may be covered if he or she is severely disabled and the condition existed prior to the child's 21st birthday—*or*, if the condition occurred between the ages of 21 and 23 while the child was enrolled in a full-time course of study in an approved institution of higher learning and is, or was at the time of the sponsor's death, dependent on the sponsor for more than one-half of his or her support. A child may also

be covered up to the 23rd birthday if he or she is in school full-time.

- **Dependents placed in the custody of a service member or former member, by a court; or by a recognized adoption agency in anticipation of legal adoption by the member.** TRICARE eligibility is effective July 1, 1994, if the child is placed by a court. A child placed by a recognized adoption agency is eligible effective Oct. 5, 1994.

- **Illegitimate children of current or former service members or their spouses may be eligible for TRICARE benefits under certain conditions.** Check with your Health Benefits Adviser (HBA), Beneficiary Counseling and Assistance Coordinator (BCAC), Health Care Finder (HCF) or TRICARE Service Center (TSC).

- **Certain family members of active duty service members who were court-martialed and separated for spouse or child abuse**. The victims of the abuse within the family are eligible for health benefits for the period that the abused dependent is receiving "transitional compensation" under Section 1059 of title 10, U.S. Code. Cost-sharing will be the same as for other active duty families.

- **Certain abused spouses, former spouses and dependent children of service members who were eligible for retirement, but had that eligibility taken away as a result of abuse of the spouse or child**. This benefit is effective for medically necessary services and supplies provided under TRICARE Standard (CHAMPUS) on or after Oct. 23, 1992.

- **Spouses and children of North Atlantic Treaty Organization (NATO) and "Partners for Peace" (PFP)**

nation representatives who are officially accompanying the NATO or PFP nation representatives while stationed in, or passing through, the U.S. on official business. These family members are eligible for outpatient benefits only (including ambulatory surgery). They are not listed in the DEERS files, and should check with a Health Benefits Adviser for assistance before getting care or filing claims.

Former Active Duty Members and Families

In addition to the categories of TRICARE-eligible persons listed above, Congress has granted eligibility for limited periods of TRICARE benefits to several categories of ***former*** active duty service members and their eligible family members (this is called the "Transitional Assistance Management Program," or "TAMP"). Here's a list of the benefit periods and those who qualify for them:

- **Sixty days** for regular Department of Defense military members who are involuntarily separated with fewer than six years of active service, and their eligible family members.
- **One hundred-twenty days** for regular Department of Defense military members who are involuntarily separated with six or more years of active service, and their eligible family members.

Eligibility is determined by the individual service branches. They also provide eligibility information to the DEERS (Defense Enrollment Eligibility Reporting System) computer

data files. TRICARE contractors then check the DEERS files for eligibility status when processing claims.

TRICARE Standard claims for persons who fall into the above TAMP categories will be cost-shared as if the sponsors and family members were active duty dependents.

Check with your nearest military personnel office for time limits or expiration dates on these benefits.

Voluntary Separation Benefits

Under the services' program to encourage certain members to leave active duty voluntarily, those who decide to accept either the lump-sum "Special Separation Benefit" (SSB) or the "Voluntary Separation Incentive" (VSI) options when they separate will be entitled to all of the benefits provided for involuntarily separated members. These benefits include the transitional health care benefits listed above. Members who choose the SSB or VSI options (and their families) may continue their health benefits by enrolling in the Continued Health Care Benefit Program (CHCBP). (See the CHCBP section earlier in this chapter for more details, and check with your HBA/TSC.)

TRICARE Standard Does Not Cover

- Active duty service members.
- Dependent parents and parents-in-law. (They are, however, eligible for care in military medical facilities on a space-available basis.)

ID Cards

To use TRICARE benefits, you must have a valid ID card issued by the uniformed services. The ID card says on the back, in the "Medical" block, whether you are eligible for medical care from military or civilian sources. Children under 10 can normally use either parent's ID card, but must be enrolled in DEERS. These children should have an ID card of their own when in the custody of a parent who is not eligible for benefits.

Newborns who need a *nonavailability statement* (see the glossary in the back of this book for a definition of this term) must be listed in the DEERS computer files even though they don't have an ID card.

Medicare and TRICARE

If you are eligible for Medicare (Part A) and are a retiree, survivor or family member of a retiree, you are not eligible for TRICARE in most situations (for exceptions, see note below).

Remember:

Even if you are not eligible for Medicare on your own, you may be eligible through your husband, wife or parent if they have worked and paid taxes under the Social Security system. If so, you are not covered by TRICARE. And it doesn't matter whether you've applied for Medicare. It matters only if you are eligible for Medicare (Part A).

Note:

Effective Oct. 1, 1991, Congress re-established TRICARE eligibility for persons under age 65 who lost their eligibility when they became entitled to Medicare Part A because of disability or because of end-stage renal disease, and who are enrolled in Medicare Part B. The law makes TRICARE pay after Medicare for these eligible persons.

For the latest information on this eligibility, including details on filing claims with TRICARE after Medicare has paid, and updating your eligibility status with DEERS, check with your nearest HBA, BCAC, or TSC.

Remember:

If you become eligible for Medicare because of disability or end-stage renal disease, you must report that eligibility to your nearest military personnel office on or after the date of eligibility.

Medicare eligibility begins on the first day of the month in which you become eligible. However, if your 65th birthday falls on the first day of the month, then your Medicare Part A eligibility begins on the first day of the *preceding* month—and your TRICARE eligibility ends. (See the "Tips on Using TRICARE" section if you are almost or past age 65.)

A Social Security Administration "Notice of Disallowance" must be submitted to the uniformed service responsible for issuance of your identification card if you're not eligible for Medicare Part A, so that a new card showing TRICARE eligibility can be issued.

If you're the spouse of a retired military sponsor who has reached the age of 65 and is, therefore, no longer eligible for TRICARE benefits, your TRICARE eligibility is not affected until you personally become 65 years old or become eligible for Medicare Part A.

All TRICARE-eligible persons, except eligible family members of active duty members (and except those persons described in the note on the previous page), lose their TRICARE eligibility when Medicare coverage becomes available to them.

Medicare Penalties

Persons who aren't eligible for Medicare Part A (hospital services), and are able to keep TRICARE after reaching age 65, may have to pay a penalty if they later become eligible for Medicare (such as through a spouse's eligibility) and sign up for Medicare Part B (medical insurance). Here's an actual case (with the names changed) which illustrates the problem:

Retired Army Sergeant Smith's wife is several years older than he is. She didn't work long enough under Social Security to be eligible for Social Security benefits including Medicare Part A, so the Social Security Administration issued her a "Notice of Disallowance." But, she was eligible for TRICARE benefits as the dependent of a military retiree. So, because she had been using TRICARE, she decided not to participate in Medicare Part B.

When Sgt. Smith was approved for reduced Social Security retirement benefits at age 62, Mrs. Smith was

already over 65. As a result of his Social Security eligibility, she became eligible for Medicare Part A, and lost her entitlement to TRICARE.

When she then tried to sign up for Medicare Part B, she found that she would have to wait until the next open enrollment period. Also, she would have to pay a 10 percent penalty on top of the regular Medicare Part B premium. In addition, her Part B benefits would not start until July 1 of the year she was able to enroll in Medicare Part B, after she enrolled during the open enrollment period.

Persons who are affected by this situation may apply to the Social Security Administration for "equitable relief" from the penalty payments, where there is reasonable evidence that an individual was not appropriately advised by the government so that he or she could make a proper choice regarding Medicare Part B. You don't have to enroll in Medicare Part B retroactively in order to get equitable relief from the penalty payments.

Any military retirees or surviving family members who might be affected by a situation like the one described above should contact the nearest Social Security Administration office regarding Medicare penalties.

If you are the widow or widower of a service member, and remarry someone outside the uniformed services, you are no longer covered by TRICARE (unless the marriage is annulled, in which case eligibility is reinstated after the annulment).

Retired reservists and their families are covered by TRICARE after the reservist reaches age 60 and begins to receive retired pay. Check with your HBA/BCAC/TSC on this.

Families of veterans with 100 percent, permanent disability, or of veterans who died from a service-connected disability, may be covered by CHAMPVA as long as they are not eligible for TRICARE. These veterans—who left active duty without qualifying for a regular military retirement—must receive their care from the Department of Veterans Affairs.

Military retirees who need treatment of service-connected conditions may choose to be treated under TRICARE or to get civilian health care that's paid for by the Department of Veterans Affairs—but not both.

DEERS

You must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) in order to receive care in uniformed services hospitals or to have claims for civilian health care processed by TRICARE. Both active and retired military sponsors and all family members must be entered in the DEERS computer data banks and shown as eligible for TRICARE benefits. Newborns should be enrolled in DEERS as soon as possible after birth, in order not to risk denial of a claim because of non-enrollment. Generally, it's the sponsor's responsibility to make sure that his or her family members are enrolled in DEERS through the nearest military personnel office. All military sponsors should ensure that the status of their families (marriage, divorce, new child, etc.), and residential

address are current in the DEERS files, so TRICARE claims can be processed quickly and accurately.

Note:

The military sponsor is responsible for disenrolling his or her family members from DEERS when they are no longer eligible for TRICARE (because of the marriage of a minor child, divorce of a spouse who isn't eligible for continued TRICARE benefits, enlistment of a child in the military, etc.). If the sponsor doesn't do this, and an ineligible family member improperly continues to receive care under TRICARE, the government is required by law to get back the amount it paid for such care from whomever received the money. Improperly receiving care may also be considered fraudulent. For more information about this, read the section on recoupment of funds incorrectly paid in the chapter titled "How Much Will It Cost?"

Remember: TRICARE doesn't make DEERS entries. That's done through the local base's military personnel office.

If you are leaving the service, TRICARE eligibility for the family generally ends at midnight of the day that an active duty sponsor is discharged or leaves the service other than through retirement or death. For information about DEERS enrollment, contact the DEERS Telephone Center from 6 a.m.-5 p.m. Pacific Time, Monday through Friday, at the following numbers:

- 1-800-334-4162 (California only)

- 1-800-527-5602 (Alaska and Hawaii only)
- 1-800-538-9552 (all other states)

What's Covered?

Generally, TRICARE Standard covers most health care that is medically necessary. But there are special rules or limits on certain types of care. And some types of care are not covered at all.

Remember:

Just because your military or civilian doctor tells you that you need certain care doesn't mean that TRICARE Standard can help pay for it. If you're not sure whether TRICARE Standard covers a service or supply, contact your Health Benefits Adviser (HBA), your Beneficiary Counseling and Assistance Coordinator (BCAC), your TRICARE Service Center (TSC) or your regional TRICARE contractor. They can advise you about covered services, but can't guarantee that TRICARE Standard will share the cost. That determination comes later, after the claim has been submitted.

Also, be sure to check ahead of time with your HBA, BCAC, TSC, or your TRICARE contractor, to determine whether you need authorization <u>in advance</u> from the contractor for the care you seek.

In general, TRICARE Standard helps pay most doctor bills for inpatient and outpatient care that's **medically necessary** and is **not considered unproven**.

TRICARE Standard helps pay most hospital bills for semi-private rooms, meals (including special diets), diagnostic tests and treatment. It covers medical supplies such as bandages and syringes. And, it helps pay for covered care at some health care centers other than hospitals. For example, you might need to use a residential treatment center for an emotionally disturbed child, or a drug detoxification and rehabilitation center. The types of other health care centers covered by TRICARE Standard are listed in the chapter titled "Where to Get Care."

Much of the rest of this chapter is taken up with the following alphabetical listing and brief explanation of various types of care that are covered by TRICARE. **Remember:** ***You may need advance authorization from the contractor for the care you receive. Always check before getting the care.***

Special Benefits and Certain Limits

Alcoholism (and Other Substance Use Disorders)

Treatment for alcoholism or the abuse of other substances is considered mental health treatment by TRICARE Standard and is subject to the same pre-authorization requirements as mental health care. Alcoholism (or other substance use disorder) treatment includes:

Hospital Care

TRICARE Standard helps pay for up to seven days of detoxification in an authorized substance use disorder rehabilitation facility. This may be needed when the patient suffers from delirium, confusion, trauma, unconsciousness or malnutrition. The seven days are included in the maximum of 30 or 45 days (depending on the patient's age) of inpatient mental health care allowed per fiscal year, but don't count toward the 21 days of rehabilitation mentioned below.

Rehabilitation Stays

In addition to the seven-day detoxification period mentioned above, TRICARE Standard helps pay for up to 21 days of rehabilitation (this is included in the 30 or 45 days of inpatient mental health care allowed per fiscal year). But it is limited to 21 days per 365-day period and only three inpatient admissions during the person's life. And it's covered only in a hospital or special treatment center whose alcohol or other substance use disorder rehabilitation facility has entered into a participation agreement with TRICARE. Before getting care, check with the TRICARE claims processor to make sure the hospital or center is approved by TRICARE.

Treatment for alcoholism or other substance use disorders includes "partial hospitalization" in an authorized substance use disorder rehabilitation facility. Partial hospitalization is when the patient spends at least three hours a day at the facility, five days a week (the treatment may also occur on weekends or in the evening), then goes home at night. TRICARE Standard shares the cost of this treatment up to 21 days at a pre-determined, all-inclusive *per diem* rate.

Outpatient Care for Alcoholism or Other Substance Use Disorders

It's covered for up to 60 visits over the course of a "benefit year," beginning the day the person starts receiving the rehabilitation phase of treatment.

Family therapy is covered for up to 15 visits per year, also beginning the day the therapy starts.

Waivers to the limits on care can be granted if the continued care meets certain requirements. This is true of both inpatient care and partial hospitalization.

Ambulances

TRICARE Standard cost-shares ambulances only when medically necessary; that is, the patient's condition does not allow use of regular, private transportation or taxis, "medicabs" or "ambicabs." And, it must be needed for a medical condition that is covered by TRICARE Standard.

TRICARE Standard shares the cost of an ambulance for transfers between any two points determined to be medically necessary for the covered medical condition, such as from home to hospital, or between hospitals. If the ambulance is ordered from a military hospital, TRICARE Standard can't pay for it—the military hospital must pay. Ambulance transfers between hospitals are currently cost-shared on an inpatient basis. Ambulance service to or from a hospital (for example, between the hospital and your home) is still cost-shared on an outpatient basis. Check with your HBA, BCAC, or TRICARE Service Center (TSC) if you have questions about this.

Any Care that Lasts a Long Time

Any type of care that goes on for a long time (over a period of days or weeks, etc.), such as physical therapy, regular medication or mental health services, may need certain reviews and paperwork to be completed before, during and after the course of treatment. Be sure to check with your HBA/BCAC/TSC.

Biofeedback

Only certain types of therapy (electrothermal, electromyograph and electrodermal) are covered and only when the patient's condition is documented as not having responded to other forms of conventional treatment. There are other limits as well. Check with your HBA/BCAC/TSC before beginning biofeedback therapy.

Cancer Test Project Expansion

A Department of Defense/National Cancer Institute (NCI) demonstration project that has allowed TRICARE patients access to promising cancer treatments has been expanded to include cancer prevention strategies, as well.

The expansion of the test permits eligible patients who meet clinical criteria to participate in NCI-sponsored Phase II and Phase III clinical trials in cancer prevention, in addition to cancer treatment.

The original demonstration, which began in 1994, allowed CHAMPUS to reimburse the costs for eligible patients who requested treatment for breast cancer under NCI-sponsored

clinical trials. Effective Jan. 1, 1996, the demonstration was expanded to include treatment for other cancers. Effective June 10, 1999, it was expanded to include prevention strategies.

Patients who want to participate in an NCI-sponsored clinical trial must first have their physician confirm with the proper TRICARE contractor for the demonstration (currently Palmetto Government Benefits Administrators—or "PGBA") that the proposed trial falls under the terms of the demonstration project. The physician must then receive authorization from PGBA for the patient to be evaluated at the institution conducting the study. If the patient is eligible for the study and agrees to participate, the physician must contact PGBA for treatment authorization.

PGBA staff members are available to answer questions from patients about the demonstration project and to provide treatment authorization for providers of care. PGBA's toll-free telephone number is 1-800-779-3060.

Participating institutions include a nationwide network of 2,000 facilities, including comprehensive and clinical cancer centers, community hospitals and practices, and military medical facilities.

Normal TRICARE cost-shares and deductibles, and other rules, policies and regulations, will apply for demonstration participants. Transportation costs are borne by the patient.

Cardiac Rehabilitation

Certain cardiac rehabilitation programs are covered for inpatient or outpatient care. Services and supplies must be

provided by TRICARE-authorized hospitals and ordered by physicians as treatment for patients who have experienced any of the following conditions or events during the preceding 12 months:

- Myocardial infarction (heart attack).
- Coronary artery bypass graft.
- Coronary angioplasty (surgical reconstruction of coronary blood vessels).
- Heart-valve surgery.
- Heart transplants, including heart-lung transplants.
- Percutaneous transluminal coronary angioplasty (use of balloon catheter inserted into a coronary blood vessel to flatten plaque against the artery wall).
- Chronic stable angina (chest pain)—subject to certain limitations.

Outpatient cardiac rehab treatment is limited to 36 sessions per cardiac event, and in some cases, one series of treatments in a calendar year. There are other limits as well. TRICARE Standard won't cost-share programs designed primarily for lifetime maintenance that are performed at home or in medically unsupervised settings, or for non-hospital-based cardiac rehab programs. Check with your HBA/BCAC/TSC for other restrictions.

CT Scans and Magnetic Resonance Imaging (MRI)

Computerized tomography (CT) can be cost-shared by TRICARE Standard. But the doctor must ***first*** try other diagnostic tests that can give the desired medical information and are less expensive and non-invasive (that is, involve no insertion of an instrument or foreign material into the body), unless the CT scan is considered the most appropriate diagnostic test.

Magnetic resonance imaging (MRI) is a "no-radiation" way of producing high quality images of cross-sections of the body in order to spot internal abnormalities or diseases. TRICARE Standard cost-sharing of MRI is limited to medically necessary and appropriate use of the procedure on soft tissue areas within the body, using only MRI equipment approved by the Food and Drug Administration and used within its guidelines. TRICARE Standard won't cost-share MRI for certain kinds of patients, such as pregnant women or acutely ill patients on certain kinds of life-support systems. Contact your HBA or BCAC for more details on coverage limits and requirements for MRI, or check with the TRICARE contractor for the pre-authorization requirements for your region.

Dental Care

Important Note:

The dental coverage discussed below is ***not*** *part of, and has nothing to do with, the uniformed services' TRICARE Active Duty Family Member Dental Plan. (See the chapter later in the handbook for information*

on the TRICARE Active Duty Family Member Dental Plan.)

For the most part, TRICARE Standard does not cover dental care. The only time it's covered is when it's a medically necessary part of medical treatment that is covered by TRICARE Standard. And in such cases, you must get approval from your TRICARE contractor before you get care from a dentist (oral surgery does not need advance authorization). (See "How to Get Approval for Dental Care" in this chapter.) TRICARE covers dental care only when:

- It is a necessary part of other medical care that is covered. For example, an oral surgeon may have to remove broken teeth as part of the medical treatment for an injury.
- Or, a medical problem requires that you must go into the hospital as an inpatient for dental work. For example, people with blood disorders such as hemophilia may be hospitalized for dental treatment so that any bleeding caused by the dental work can be stopped. In this case, TRICARE Standard pays for only the hospital part of the bill, not for the dental inpatient care, and for any care that is medical, not dental. For example, anesthesia used in conjunction with the dental work is not cost-shared by TRICARE Standard.

Dental Plan for Retirees

In early 1998, the Defense Department began offering the TRICARE Retiree Dental Program (a program paid for in total by enrollees) to retired military members (including the U.S. Coast Guard), their

eligible family members, and un-remarried surviving spouses of deceased military retirees (there are no age limits on eligibility). The program features a variety of diagnostic, preventive, restorative, endodontic, periodontic and oral surgery services, at specified levels of cost-sharing.

The program is paid for by premiums collected from enrollees through payroll deduction from those who receive retired pay. Those who don't receive retired pay are billed directly for premiums by the contractor that administers the program.

Initial enrollment in the program is for at least 24 months. Enrollees must submit a payment equal to four months' worth of premiums with their initial enrollment application. After the first 24-month period, enrollees may choose to stay enrolled on a month-to-month basis.

More information (including what services are not covered) is available on the contractor's Web site, at: **www.ddpdelta.org**. *Or, check with your HBA, BCAC, or TRICARE Service Center for details.*

Dental Plan for Reservists

The Defense Department now makes available to all members of the Selected Reserve of the uniformed services a dental program called the TRICARE Selected Reserve Dental Program (TSRDP). This plan offers diagnostic, preventive, oral surgery and emergency dental services. Coverage is limited to

reservists only; family members are not covered under this plan, as it currently exists.

The maximum annual benefit for services under the plan is $1,000 worth of paid allowable charges per enrollee per contract year. The government will pay 60 percent of the cost of each reservist's monthly premium. The reservist's share of the monthly premium won't be more than $25. Enrollees must submit four months' worth of premium payments with their initial enrollment form. After that, they may make monthly payments to the contractor that's chosen to operate the program. Reservists who are in "pay" billets will have their share of the monthly premium withheld from their monthly drill pay.

Reservists who want to learn more about the TSRDP may contact their reserve units or local reserve centers for information—or, check out the contractor's Web site at: **www.humana-military.com**.

***Note*: Two TRICARE dental plans will join forces in February 2001, and will provide improved coverage for military sponsors and families in the process. The two plans are the TRICARE Selected Reserve Dental Plan (described above), and the TRICARE Family Member Dental Plan (described later in this book), which serves active duty families. The TRICARE Retiree Dental Plan will remain separate from the new combined plan.**

The new, single plan—which will be known as the TRICARE Dental Program (TDP)—is scheduled to begin operation Feb. 1, 2001. It will feature improved benefits, easier, more efficient enrollment, and expanded eligibility.

Check with your nearest TRICARE Service Center, Beneficiary Counseling and Assistance Coordinator or Health Benefits Adviser for details.

Drug Abuse

Treatment for drug abuse (substance use disorders) is covered on an inpatient or outpatient basis in an authorized treatment facility. Like treatment for alcoholism (see the "Alcoholism" section earlier in this chapter), it's covered under the general category of mental health treatment. (See the discussion of mental health coverage later in this chapter, and contact your nearest Health Benefits Adviser (HBA), Beneficiary Counseling and Assistance Coordinator (BCAC), TRICARE Service Center (TSC) or Health Care Finder (HCF) for additional details.)

Durable Medical Equipment

Durable medical equipment, like wheelchairs, hospital beds and respirators, can be cost-shared by TRICARE Standard. You can rent, sometimes "lease/purchase," or buy the equipment (whichever method is least expensive for the government). A doctor's prescription specifying the particular type of equipment you need, why, and for how long you need it, must be sent in with your claim. Your HBA/BCAC/HCF can help you find a medical supply firm or pharmacy that accepts TRICARE Standard terms. Equipment that is for general use—such as air cleaners or whirlpool baths—is not cost-shared by TRICARE Standard, even though a physician may have prescribed it. Because it can be complicated, be sure to check with

the HBA/BCAC/TSC before getting any durable medical equipment. If you live within the ZIP code area of a military hospital, check with the HBA there to see if the needed equipment is available on loan.

Remember:

The HBA/BCAC/TSC can give you information, but can't guarantee payment by TRICARE Standard. ***Make sure you get the exact equipment that you ordered****. If you don't get the proper equipment, notify your HBA/BCAC/TSC.*

Eye Examinations

One screening eye examination per person, per 12-month period, is authorized for active duty families only. The exam may include a check of the internal and external structures of the eye for disease and signs of other disease and evaluation of the patient's vision and other health. It may be performed by an ophthalmologist or an optometrist.

An eye exam will be covered for any TRICARE Standard-eligible person if the exam is related to a covered medical condition, such as cataracts or an eye injury.

Family Planning

TRICARE Standard Covers:

- Infertility diagnosis and treatment. (Remember, TRICARE Standard does not cover the active duty sponsor.)

- Intra-uterine devices (IUDs).
- Measurement for, and purchase of, contraceptive diaphragms.
- Birth control pills or injections your doctor prescribes.
- Norplant System long-term reversible contraceptive implants.
- Tests to find out if you're pregnant (not over-the-counter self-tests).
- Sterilization—vasectomy or tubal ligation; check with your HBA/BCAC/TSC for limitations.

TRICARE Standard Does Not Cover:

- Over-the-counter contraceptives—such as prophylactics (condoms) and spermicidal foams.
- Surgery to reverse sterilization.
- Artificial insemination—including sperm banks/donors, in vitro fertilization and other artificial means of conception.
- Abortions. ***Note***: In *extremely limited* circumstances, when the physician certifies that the life of the mother is endangered, TRICARE Standard can cover abortions; check with your HBA/BCAC/TSC.

Having a Baby

Genetic Tests

Genetic tests to find out if your unborn child has genetic defects are covered. But TRICARE Standard helps pay **ONLY** if:

- You are a pregnant woman 35 years old or older, or
- You had rubella during your first three months of pregnancy, or
- You or your husband have had a child with a genetic (congenital) defect, or
- You or your husband come from a family that has a history of genetic (congenital) defects.

TRICARE Standard cannot help pay for genetic tests:

- Not ordered by a doctor.
- To tell who is the father of the child.
- To tell if your unborn child will be a boy or a girl.

Note:

Chromosome analysis in cases of infertility or where fetuses are repeatedly miscarried is considered a diagnostic service, and is not subject to genetic testing limitations.

Maternity Care

If you become pregnant, TRICARE Standard helps pay for the maternity care you need. This is true during your pregnancy, delivery of the baby, and up to six weeks after the baby is born.

However, if an active duty member is discharged from the service while his wife is pregnant, TRICARE Standard does not cover any maternity care after the day of discharge, unless the family qualifies for the Transitional Assistance Management Program—or has enrolled in the Continued Health Care Benefits Program. (See the "Who's Covered?" chapter for details.)

Remember:

"Maternity care" is the care you need because you are pregnant or for complications from pregnancy. For example, treatment for a sprained ankle during pregnancy is not maternity care. Furthermore, TRICARE Standard can share the cost only of maternity care that is covered. For example, vitamins during pregnancy are not covered. Prescription drugs related to the maternity care are covered.

Soon after you find out you're pregnant, decide where to have the baby. Do you plan to have the baby at a hospital or other health care center where you stay overnight? If so, you'll be an inpatient. Or do you plan to have the baby at home or at a participating TRICARE Standard-authorized "freestanding" birthing center or hospital-based birthing room? If so, you'll be an outpatient.

Nonavailability Statements for Maternity Care

In a recent change, TRICARE has reimposed the requirement (which had previously been in effect before fiscal year 1997) that—except for emergencies—maternity patients who live in a uniformed-services hospital's ZIP code service area (also called a "catchment area"), and who are not enrolled in TRICARE Prime, generally must get all of their maternity care—***both inpatient and outpatient***—from that hospital. If the service hospital can't provide the needed maternity care, it will issue a nonavailability statement (NAS) to the patient, who may then seek care from a civilian source.

Patients who don't live within the ZIP code service area of a uniformed services medical facility will not have to get an NAS for their civilian maternity care.

The NAS is a certification, issued by the military hospital, that a specific medical service is not available to the patient, at the time the patient seeks the service.

Maternity patients will need one NAS for all of the maternity care associated with the pregnancy. The NAS is needed for the first pre-natal visit after confirmation of the pregnancy, and will remain valid for 42 days (six weeks) following the delivery.

Patients who have other health insurance that pays before TRICARE are exempt from the NAS requirement (*but, check to see if your TRICARE contractor has established any other requirements for prior authorization for care*). The other health plan must be a medical-hospital-surgical plan that at least covers inpatient hospitalization of the patient.

The new NAS requirement for both inpatient ***and*** outpatient maternity care is effective for all maternity care in which the patient's first pre-natal doctor visit was ***on or after*** Oct. 5, 1999.

Previously, TRICARE-eligible maternity patients who lived within service hospitals' ZIP code service areas needed NASs for ***inpatient*** deliveries at civilian facilities, but did not have to get NASs for ***outpatient*** pre-natal or post-partum (after the birth) maternity care. This rule is still in place for patients whose first pre-natal doctor visit occurred ***before*** Oct. 5, 1999.

Inpatient Deliveries

If you live in the designated ZIP code service area around a military hospital, you must plan to get all of your inpatient maternity care at that hospital. If the military hospital can't provide all of your inpatient maternity care, ask for a nonavailability statement (NAS). You must get the military hospital to file a nonavailability statement electronically in the DEERS computer data bank. You can also ask for a "hard copy" of the NAS from the military medical facility, and file it with the claim that's sent to the TRICARE claims processing contractor. Check with your HBA/BCAC if you aren't sure whether your home address falls within the ZIP code zone. (See additional details about nonavailability statements in the previous section, and in the "Where to Get Care" chapter.)

If you do need to go to a civilian hospital or doctor, it will save you money if you find one who participates in TRICARE Standard. (For a more complete discussion of providers who do or don't participate, see the "Where to Get Care" chapter.)

Getting Inpatient Maternity Care From Providers Who Participate in TRICARE Standard

Hospitals and doctors who participate in TRICARE Standard receive the TRICARE Standard "allowable charge" for their services. However, you must still share some of the costs as follows:

- If you're the wife of an active duty member, TRICARE Standard pays for all of the covered maternity care from your doctor. For the hospital's costs, you must pay a small amount for each day that you're in the civilian hospital. This daily rates are subject to change. In fiscal year 2000, it's $10.85 per day, with a minimum total charge of $25.
- For unmarried daughters of active duty members and retirees, TRICARE Standard will share covered maternity costs for the mother, but not medical care costs for the baby. After delivery, the baby is not eligible for TRICARE Standard, unless the father is an active duty member or a retiree and a court recognizes him as the father—or unless the military sponsor adopts the child, or has custody awarded by a court.
- If you are a retiree or the wife of a retiree, you'll pay the lesser of 25 percent of the hospital's billed charges or a fixed daily amount (currently $390, but subject to change) under the TRICARE Standard "diagnosis-related group" (DRG) payment system. TRICARE Standard pays the rest. Or, in the few areas or hospitals that don't have the DRG payment system, you'll pay 25 percent of the allowable maternity costs, and TRICARE Standard will pick up the other 75 percent (see the "How Much Will it Cost?" chapter

or the Glossary for explanations of the DRG payment system).

- For claims purposes, newborn infants are treated as separate patients during their stay in a hospital that comes under the DRG payment system. After that, they will be charged a cost-share, whether the mother continues to be hospitalized or not. Infants who are delivered in a hospital that does not come under the DRG system (such as hospitals in Maryland) will be charged a cost-share for every day after the third day of their hospital stay. For nonavailability statement (NAS) requirements, check with your HBA/BCAC/TSC. (See the "DRG Hospital Payment Rules" section in the "How Much Will It Cost?" chapter for a more complete discussion of the TRICARE Standard DRG payment system.)

Getting Inpatient Maternity Care From Providers Who Don't Participate in TRICARE Standard

If the hospitals or doctors don't participate in TRICARE Standard, you must arrange with them to pay your bills. They may charge more than the TRICARE Standard "allowable charge."

Note:

They shouldn't charge more than the legal limit—15 percent above the TRICARE allowable charge. See the chapter titled "How Much Will It Cost?" for more details.

If these providers charge ***more*** than the legal limit of 15 percent above the TRICARE allowable charge, **they cannot expect to receive any more reimbursement than the legal limit under federal law**, as described above.

TRICARE Standard pays the government's share of the allowable charge for covered care. You must pay the difference, and are responsible for paying the provider's full bill, up to the legal limits.

Hospital Birthing Rooms or Centers

If you plan to have your baby in a birthing center or a hospital outpatient birthing room, TRICARE Standard can cost-share the delivery and all of your maternity care at inpatient rates if you're an active duty member or NATO family member (the care will be cost-shared at outpatient rates for all other TRICARE-eligible persons). That's true even if you don't stay in the hospital's outpatient birthing room for 24 hours. Check with your HBA/BCAC/TSC or claims processor to make sure the center is approved by TRICARE Standard. (See the "Outpatient Deliveries" section immediately following for information about freestanding birthing centers.)

Maternity Claims

Under the "diagnosis-related groups" (DRG) payment system, separate claims must be filed for the mother and the newborn child. Your hospital will take care of this for you.

Outpatient Deliveries

Do you plan to have the baby as an outpatient (that is, you won't be admitted to a hospital to give birth)? If you have your baby as an outpatient, TRICARE Standard helps pay for your maternity care on an outpatient basis, as follows:

The Outpatient Deductible

As with all outpatient care, you are responsible for the deductible for the fiscal year—Oct. 1 through Sept. 30. The claims processor subtracts your deductible from TRICARE Standard payments on your claims during the fiscal year, and applies amounts to your deductible from claims being processed.

Getting Outpatient Maternity Care From Providers Who Participate in TRICARE Standard

Providers who participate in TRICARE Standard receive the TRICARE Standard allowable charge for their services. However, you still must share some of the costs, as follows:

- If you are the wife or unmarried daughter of an active duty member, TRICARE Standard pays generally 80 percent of your covered maternity costs. You must pay the other 20 percent, unless you use a freestanding birthing center. (See the upcoming section on freestanding birthing centers.) For unmarried daughters, TRICARE Standard pays none of the baby's bills, unless the father is an active duty, retired or deceased service member, and a court recognizes him as the

father—or unless the baby is adopted by the sponsor, or placed in the custody of a sponsor by a court.

- If you are a survivor, retiree or the wife or unmarried daughter of a retiree, TRICARE Standard pays 75 percent of your covered maternity costs. You must pay the other 25 percent.

Getting Outpatient Maternity Care From Providers Who Don't Participate in TRICARE Standard

If the hospitals or doctors don't participate in TRICARE Standard, you must arrange with them to pay your bills. The law says they may charge up to 15 percent more than the TRICARE Standard allowable charge. TRICARE Standard pays the providers the government's share of the cost of covered care. You must pay the difference, up to the legal limit. (See a discussion of the limits on medical bills in the chapter titled "How Much Will It Cost?")

If You Plan to Deliver at Home

Even though you plan to have your baby at home, if you live in the designated ZIP code zone around a military hospital, contact the Health Benefits Adviser/Beneficiary Counseling and Assistance Coordinator/TRICARE Service Center to find out if the hospital can provide inpatient maternity care. If it can't, ask for a nonavailability statement (NAS) right away!

Why? Suppose you plan to have your baby at home. But at the last minute, you decide to go to a hospital instead. Or, you might have problems with your pregnancy or delivery and need

to go to a hospital. You must have the NAS before you go to the civilian hospital if TRICARE Standard is to share any of your maternity care costs.

Note:

While certified nurse midwives can be authorized TRICARE Standard providers of care, "lay" midwives (midwives who are not registered nurses) are not authorized under TRICARE Standard.

Freestanding Birthing Centers

TRICARE Standard cost-shares the use of approved freestanding birthing centers that agree to participate in TRICARE Standard. Birthing centers may be "freestanding" (separately located and not having any official connection with a "parent" institution), or they may be affiliated with, and even located at, another institution. They must be authorized as providers of care under TRICARE Standard and must have signed a participation agreement with TRICARE Standard. These birthing centers provide services for low-risk (normal) pregnancies and are limited to the use of natural childbirth procedures. Active duty dependents pay $25 to use them and to use hospital-based birthing rooms for outpatient deliveries. For other TRICARE-eligible persons, cost-sharing will be on a standard outpatient basis. For more information, contact your nearest Health Benefits Adviser, Beneficiary Counseling and Assistance Coordinator or TRICARE Service Center.

Ambulance Costs for Maternity Care

No matter where you plan to have your baby, TRICARE Standard may share ambulance costs on an inpatient or outpatient basis. (See the section on "Ambulances" earlier in this chapter.)

Care for Your Baby

For routine newborn care, separate claims are filed, but the baby's care is paid as part of your maternity care for the first three days. After three days, the baby begins separate cost-sharing as an individual at the normal rate, and may require a nonavailability statement (NAS). (See additional discussions of this in the sections on providers who participate in TRICARE Standard for maternity care, earlier in this chapter.)

Note:

TRICARE Standard cannot cost-share the charges for grandchildren of active duty, retired or deceased members, unless the child's father is an active duty member or retired service member—or unless the child is adopted by the sponsor, or placed in the sponsor's custody by a court.

If your baby has to stay in the hospital more than three days, stays after you leave, or needs other than routine newborn care while you're both still in the hospital, the baby is considered a patient in his/her own right. That means claims must be sent in separately for the baby's non-routine care. If you live in a military hospital's ZIP code zone, and your baby must stay in a civilian hospital after you leave the civilian

facility, you may need to get a nonavailability statement for the baby from the military hospital, within 15 days of your own discharge from the civilian hospital. Or, the baby may have to be transferred to the military hospital if it can provide the care.

After you both leave the hospital, your baby becomes a TRICARE Standard beneficiary in his/her own right—the baby may have already become one if his/her hospital stay lasted more than three days. That means claims for the baby's care must be sent in and TRICARE Standard shares the costs on the same basis as for anybody covered by TRICARE Standard.

Note:

Be sure to enroll your baby in DEERS as soon as possible. TRICARE Standard will deny payment on claims for the baby unless he or she is listed in the DEERS files as being eligible for TRICARE benefits.

Well-Baby and Well-Child Care

In an expansion of TRICARE Standard and TRICARE Extra health benefits, eligible children who haven't reached the age of 6 may now receive well-child care—like the services currently available to those who enroll in the TRICARE Prime HMO-type health care option—from authorized civilian providers of care. Well-child care was previously limited to children up to the age of 2.

The extended benefit, which was effective on Oct. 6, 1997, includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and

developmental assessment in accordance with American Academy of Pediatrics guidelines.

Well-child care is covered for children from birth to age 6 when services are provided by the attending pediatrician, certified nurse practitioner, or certified physician assistant.

For children whose health screening and immunizations aren't up-to-date, TRICARE will cost-share visits and immunizations up to midnight of the day before the child turns 6 years old.

Well-child care for newborns includes the routine care of the baby in the hospital, and a variety of tests, as well as newborn male circumcision. After the baby goes home, up to nine well-baby visits in a two-year period are covered. The visits will include such things as a history, physical exam, and mental health assessment, and a developmental and behavioral evaluation.

Well-child care is cost-shared on either an inpatient or outpatient basis, depending on whether the child is hospitalized or not. The well-child care program includes such procedures as:

- Immunization, according to recommendations by the Centers for Disease Control.
- Heredity and metabolic screening.
- Tuberculin tests, at 12 months of age, and once during the child's second year.
- Hemoglobin or hematocrit testing, once each during the first and second years.

- Urinalysis, once each during the first and second years.
- Annual blood pressure screening between 3 and 6 years of age.
- Blood lead test, during each well-child visit from the age of 6 months up to age 6.
- Health guidance/counseling, including breast feeding and nutrition counseling.
- Additional services or visits that may be required because of specific findings.

Of course, TRICARE Standard also covers other types of medical care for the child, as it would for any eligible person.

For children aged 6 and older (indeed, for all dependents), immunizations are also covered, and can be provided independently of other preventive services. Preventive services similar to those offered to TRICARE Prime enrollees must be provided in connection with immunizations, pap smears, mammograms, and certain other cancer screenings. For example, if an eligible female goes in for a routine pap smear, she is also eligible to receive a wide variety of other preventive services, such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening tests, and preventive counseling services, to name a few. But the same coverage won't be available if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (pap smear, mammogram, immunization, etc.) are not performed.

Hospice Care

TRICARE Standard now covers the cost of hospice care for terminally ill patients who are expected to live less than six months if the illness runs its normal course. There are no limits on custodial care and personal comfort items under hospice care rules, as there are with other types of care. Also, there are fewer restrictions than in other types of TRICARE Standard-covered care. And, TRICARE Standard pays the full cost of covered hospice care services, except for small cost-share amounts which may be collected by the hospice for such things as drugs and inpatient respite care. Check with your HBA/BCAC/TSC or your TRICARE contractor for details.

Implants

Surgical implants are covered when they are of a type approved by the Food and Drug Administration.

Examples: Intraocular lenses, which are implanted in the eye after cataract surgery; cochlear implants, which are electronic instruments surgically implanted in the ear to assist in hearing; breast implants for reconstructive surgery following surgical removal of the breast; and penile implants to correct malformation of the male sex organ which has existed since birth; to correct organic impotency; or to correct what the medical profession calls "ambiguous" reproductive organs.

There are limitations to all of these procedures, so check with your HBA/BCAC/TSC before having any type of surgical implant.

Individual Case Management

The new **individual case management** benefit (which was effective March 15, 1999) allows TRICARE-eligible persons who have extraordinary medical or psychological disorders to receive health care benefits that would normally be limited—or not covered at all. Individual case management is intended to address the complex health care needs of catastrophically ill or injured persons. Designed to improve the quality of care, control costs, and support patients through catastrophic medical situations, it provides a transitional bridge between acute-care and long-term-care services. It offers a system for organizing multi-disciplinary services that are often required for the management of extraordinary medical or psychological disorders.

Note:

"Individual case management" is different from "case management" in the more broad-based, generic sense of the term. "Case management" in the broad sense occurs when current benefits available under TRICARE need to be monitored and coordinated to meet the individual's health needs.

Waivers of normal benefit limits or exclusions under individual case management will be approved and coordinated by case managers, and must be cost-effective and appropriate. The waivers may include—but are not limited to—services or supplies such as home health care, medical supplies, backup durable medical equipment, extended skilled nursing care, and home health aides.

The individual case management program is separate and distinct from benefits available under the Program for Persons with Disabilities, and from benefits under "generic" case management (see note above).

Patients who want to participate in the individual case management program should contact (or have their representatives contact) their nearest TRICARE Service Center or Health Benefits Adviser for more details about specific requirements, and about how to get into the program.

Mammograms and Pap Smears

Routine mammograms and pap smears are covered as diagnostic or preventive health care measures. There are certain rules regarding frequency of the procedures and as to who may provide the services. Check with your HBA/BCAC/TSC for details.

Medical Equipment and Supplies

For medical supplies (such as needles or syringes) and medical equipment under $100 (such as crutches), a doctor's prescription must be sent in with your claim (durable medical equipment worth more than $100 also needs a prescription). Your HBA/TSC will be able to help find a medical supply firm or pharmacy that accepts TRICARE Standard terms.

Medications

Food and Drug Administration-approved medications are covered (example: the AIDS medication Zidovudine, also called "AZT" and sold under the commercial name "Retrovir"). If you aren't sure whether your medication is approved by the FDA and covered by TRICARE Standard, check with your HBA/BCAC/TSC.

TRICARE contractors may fill prescriptions with generic equivalents of brand-name drugs. Check with your contractor for details.

Prescription medications may be purchased through either TRICARE-approved pharmacies or the National Mail Order Pharmacy Program (NMOP). Call NMOP in the U.S. toll-free, at 1-800-903-4680. Outside the U.S., call 1-800-903-4680 or (614) 421-8211. Check with your HBA/BCAC/TSC to find the nearest TRICARE network pharmacy.

Note:

Medications that are available "over-the-counter"—that is, without a prescription—are not cost-shared by TRICARE, even if your physician recommends them.

Mental Health

TRICARE Standard helps pay for psychotherapy, either in the hospital or on an outpatient basis. If your provider of care believes you need more than five psychotherapy sessions a week in the hospital, or more than two psychotherapy sessions a week as an outpatient, a TRICARE contractor must review the medical necessity for the care. If you need more than eight

outpatient psychotherapy sessions in a fiscal year, approval is required. You must get approval for additional sessions from your regional TRICARE contractor.

Remember:

The sessions cannot simply be counseling sessions, such as for people who are having marital or family disagreements. They must be for treatment of a mental disorder that has a medical diagnosis.

Inpatient care, which needs advance authorization by a TRICARE contractor, is limited to a certain number of days per year unless TRICARE grants a waiver. The limits don't apply to services provided under the Program for Persons with Disabilities.

Note:

TRICARE Standard has expanded its coverage of "partial hospitalization" beyond alcoholism or other substance use disorder rehabilitation to include other mental health disorders. Partial hospitalization is when a patient checks into a health care facility on a given day for treatment, but goes home at night.

The expanded benefit is effective for care received from TRICARE Standard-authorized partial hospitalization programs, and is limited to 60 days of treatment per fiscal year, with waivers for unusual cases.

The annual limits for inpatient mental health care covered by TRICARE Standard are as follows: (1) 30 days for patients

aged 19 or older; (2) 45 days for patients under age 19; (3) 150 days for inpatient care in residential treatment centers.

Remember:

Before getting mental health care, be sure to check with your HBA/TSC because ***prior approval*** may be required. Also, certain reviews and paperwork must be completed at various points before, during and after mental health care for TRICARE Standard to share the bills. (See the section in this chapter titled "Some Care Needs Special Authorization" for details about required advance approval for mental health care.)

Obesity Treatment

TRICARE Standard coverage is limited to three types of surgical treatment for obesity: gastric bypass, gastric stapling and gastroplasty, including "vertical banded" gastroplasty, when one of the following conditions is met:

- A patient is 100 pounds or more over the ideal weight for height and body structure, and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian Syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.
- A patient is 200 percent or more of the ideal weight for height and body structure. An associated medical condition is not required for this category.
- A patient has complications from a non-covered surgical treatment for obesity, such as intestinal bypass, and needs one of the three surgical procedures that are covered.

TRICARE Standard does not cover any other services or supplies related to obesity or weight reduction. Non-surgical treatment of morbid obesity, such as wiring the jaws or special diets, is not covered.

Organ Transplants

TRICARE Standard covers the following organ transplants: cornea, kidney, liver, liver-kidney, heart, lung, heart-lung, small-intestine, combined small intestine-liver, simultaneous pancreas-kidney, and some bone marrow. But there are limits in some circumstances. For example, bone marrow transplants are not covered for treatment of ovarian cancer. Contact your HBA/TSC or contractor ahead of time for details on organ transplants. Some organ transplants may only be provided in facilities that are authorized specifically for the particular type of transplant. Some organ transplants may also require advance authorization. Check with your HBA/BCAC/TSC for authorization requirements, and for more information about any additional transplants that may have been added to the approved list since this handbook was published.

Plastic or Reconstructive Surgery

TRICARE Standard covers plastic, cosmetic and reconstructive surgery only in the following situations:

- Plastic surgery can be cost-shared when it is needed to restore function. For example, plastic surgery on a patient's nose would be covered if it were necessary for the patient to breathe. It would not be covered just to improve the person's looks. Because this can be a gray area, check with

your HBA, BCAC, or the regional TRICARE contractor if you have questions, before getting care.

- Plastic surgery can be cost-shared for the following reasons:
  - To correct a serious birth defect, such as a cleft lip.
  - To restore body form or function after an accidental injury.
  - To improve appearance after severe disfiguration or extensive scarring from surgery for cancer.
- Breast reconstructive surgery after a mastectomy is covered by TRICARE Standard regardless of when the mastectomy was performed.
- Breast construction by surgery is covered by TRICARE Standard. Along with the claims for constructive breast surgery, documentation must be submitted showing that the condition had existed since birth or was caused by an accident. TRICARE won't share the cost of reconstructive surgery for a breast that is simply incomplete or underdeveloped.
- Breast reduction surgery may be covered under limited circumstances, for documented, intractable pain that doesn't respond to other treatments. Check with your HBA or BCAC for details.

Prescription Drugs

Claims for covered prescription drugs can be submitted on the CHAMPUS claim form (DD Form 2642). The old form, the DD Form 2520, may still be used overseas.

You need special billing information for filing a claim for prescription drugs. (See the "Fully Itemized Bills" section in the chapter titled "How to File a Claim" for details.)

Note: *The Defense Department is currently working on a major redesign and integration of the pharmacy benefit for all three TRICARE options. As it stands now, you can get pharmacy services in any of several ways: through pharmacies at military medical facilities; through civilian retail pharmacies (which may or may not be part of a TRICARE contractor's network); and through a national mail-order pharmacy system. Presently, each is a separate program without any coordinated exchange of information among the three systems.*

The thrust of DoD's redesign of the pharmacy benefit is to improve communication among the programs, increase the uniformity of the benefit, ensure safety for patients through better tracking of drug prescriptions across the three systems, and to control costs.

Pharmacy Redesign Pilot Program*—As part of the integration and redesign of the pharmacy benefit, a pilot program, which began in early 2000, is available to certain Medicare-eligible persons in two areas of the country. For more details about this test, see the section titled "Pharmacy Redesign Pilot Program" in the first chapter of this book, "A Look at TRICARE."*

Private Duty or Visiting Nurses

There are certain limits on TRICARE Standard coverage for private duty nursing, whether in the hospital or at home.

TRICARE Standard does not cover private duty nursing to augment the general nursing staff of a hospital, or in hospitals that have intensive-care units or coronary-care units.

TRICARE Standard does cover "skilled nursing care" at home. Medical care that only a professional can provide, such as giving certain medications, treatment or therapy, can be cost-shared. Because this can be quite complicated, check with your HBA/BCAC/TSC before you hire a visiting nurse.

Whether the private duty nurse sees you in the hospital or at home, a copy of all daily nursing notes must go in with your claim. The claim should also show the name of the doctor who referred you for private nursing and that he/she is supervising the care. A copy of the physician's treatment plan must be included with the first TRICARE Standard claim you send in.

Residential Treatment Centers (RTCs)

These are centers which provide treatment for children and adolescents (up to age 21) who require mental health care. Patients must be suffering from a serious mental disorder; children who have only disciplinary problems don't qualify. The medical necessity of a patient's admission to an RTC must be certified prior to admission by a TRICARE Standard mental health review contractor. Contact your region's TRICARE mental health review contractor for information. (See the section in this chapter called "Some Care Needs Special Authorization" for more information.) There are strict requirements for the RTCs to meet and 150-days-per-year limitations for this treatment. Before admitting your child, check with your local Health Benefits Adviser, your regional

TRICARE contractor, or with the RTC itself, to make sure the facility is TRICARE Standard-authorized. RTC care is not considered emergency care and requires prior certification by the regional TRICARE mental health contractor.

Same Day (or "Ambulatory") Surgery

Certain surgery, like having your tonsils taken out, can often be done in ambulatory surgery centers, hospitals or special centers where you can have the operation and go home the same day. This can cost less than inpatient care. For active duty and NATO families, it costs only $25 for the hospital's or surgery center's care, as long as the doctor participates in TRICARE Standard. Others pay only the lesser of 25 percent of an applicable group rate payment, or 25 percent of the billed charges, plus the annual deductible, as long as the doctor participates in TRICARE Standard. If the provider doesn't participate, you may have to pay up to 15 percent over the TRICARE Standard allowable charge, plus your cost-share and deductible, if any. (See an explanation in the "Outpatient Costs" section of the chapter titled "How Much Will It Cost?")

Don't forget to check with your Health Benefits Adviser (HBA), Beneficiary Counseling and Assistance Coordinator (BCAC), TRICARE Service Center (TSC), or regional TRICARE contractor, to see if the same-day surgery you plan to get needs authorization in advance by the contractor.

Wigs for Radiation/Chemotherapy Treatment Patients

When loss of hair is from cancer treatment, TRICARE Standard cost-shares one wig or hairpiece during a person's lifetime. Depending on whether your sponsor is an active duty service member or not, you pay either 20 or 25 percent of the allowable charge for your wig/hairpiece. The maximum TRICARE Standard allowable charge is $750. A doctor's note saying you need the wig must be sent in with your claim. And TRICARE Standard can't cost-share a wig if you've already obtained one through the Department of Veterans Affairs (formerly known as the Veterans Administration) or a uniformed service hospital.

Some Care Needs "Special Authorization"

How to Get Approval for Care under the Program for Persons with Disabilities or for Mental Health Care

For care under the *Program for Persons with Disabilities*, available to active duty family members only, contact your TRICARE contractor for instructions at least 30-60 days before you plan to get the needed care. (See the chapter titled "Program for Persons with Disabilities" for more details.)

Use DD Form 2532 or 2533 when you request approval for care under the Program for Persons with Disabilities from your TRICARE contractor. You can get the form from your HBA or your claims processor. Your doctor must send a letter to the contractor with the form explaining why you need the care.

For ***mental health care***, you'll need certification of the medical necessity for mental health care from a TRICARE contractor in the following circumstances:

1. Inpatient mental health care.
2. Care at residential treatment centers.
3. All requests for extensions to TRICARE's yearly limits on inpatient mental health care.
4. Authorizations for extended outpatient mental health care, exceeding two outpatient visits per week, five inpatient visits per week, or eight outpatient visits in a fiscal year.

Different TRICARE regions will have different contractors handling mental health care advance approval. For more information, contact your Health Benefits Adviser, Beneficiary Counseling and Assistance Coordinator, or TRICARE Service Center. Always request certification from the appropriate contractor ***before*** you start getting the care, if possible. That way, you and your provider of care will know in advance whether the planned treatment meets the TRICARE rules for medical necessity and appropriateness. The TRICARE contractor will not pay a claim until the mental health contractor's certification has been given. Remember, your HBA, BCAC, or TSC can tell you whom you need to contact to get approval for mental health care.

Remember:

Only those cases that meet the special and limited requirements for a waiver will receive approval for care beyond the annual limits of inpatient mental

health days. Authorization for the maximum number of days of mental health care in a year is not automatic. All mental health care must meet the test of medical necessity. It may be that ***fewer*** *days of such care will be paid if it is determined by the appropriate TRICARE contractor that the additional care is not medically necessary.*

How to Get Approval for Dental Care

To get approval for dental care related to a covered medical problem, check with your regional TRICARE contractor.

Reminder:

The TRICARE dental coverage discussed here is completely separate from the TRICARE Active Duty Family Member Dental Plan, or the TRICARE dental plans for reservists and retirees. It will also be separate from the new TRICARE Dental Program (a combined plan for active duty service members/reservists, and their families), which is scheduled to begin operation Feb. 1, 2001.

Approval for Organ Transplants

For some organ transplants, you must get advance approval, and you must have the transplant done at a facility that is specifically approved by TRICARE Standard for this procedure. Check with your HBA/BCAC/TSC for details.

Remember:

You must get the contractor's advance approval before TRICARE Standard will pay for the above care. Also, you must be enrolled in DEERS. (See the "DEERS" section at the end of the chapter titled "Who's Covered?")

Advance Approval for Outpatient Care

Remember that TRICARE regional contractors may require that ***all*** TRICARE-eligible persons—not just those who live within the ZIP code service area (also called a "catchment area") of a military hospital—**must have some, or *all*, outpatient procedures approved in advance by the contractor**.

Check with your TRICARE contractor, your nearest TRICARE Service Center (TSC), your Health Benefits Adviser (HBA), or your Beneficiary Counseling and Assistance Coordinator (BCAC), for more information about getting authorization ahead of time to have ***any*** procedures done. Providers of care are supposed to get these advance authorizations, whether or not they participate in TRICARE Standard. If they don't (or won't), check with the Health Care Finder at your nearest TSC to make sure that the procedure will be covered.

What's *Not* Covered?

This section lists most of what TRICARE does not cover. To be on the safe side, check with your HBA, BCAC, or TSC before getting care if you have any questions.

- **Abortions**, except when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-endangering condition existed, and must provide medical documentation to the TRICARE claims processor in order for TRICARE Standard to share the cost of the procedure.
- **Acupuncture**
- **Artificial insemination**, or any forms of artificial conception. This non-coverage includes in vitro fertilization and gamete intrafallopian transfer, as well as all other non-coital reproductive methods and all services, supplies and drugs related to them.
- **Autopsy services or post mortem examination**
- **Birth control** for which you do not need a doctor's prescription. TRICARE Standard will, however, cost-share some kinds of birth control. (See the "Family Planning" section in the chapter titled "What's Covered?" and check with your HBA/BCAC.)

- **Bone marrow transplants for treatment of ovarian cancer**. (See the section titled "Cancer Test Project Expansion" in the "What's Covered?" chapter.)
- **Camps** such as camps for diabetics or obese people.
- **Care or supplies** furnished or prescribed by a person in the immediate family.
- **Chiropractors and naturopaths**
- **Christian Science "absent treatment,"** also called "treatment through prayer and spiritual means," in which the patient is not physically present when the Christian Science service is rendered.
- **Chronic fatigue syndrome**: TRICARE Standard doesn't cover treatment for chronic fatigue syndrome (CFS) as a defined illness, since there are no generally accepted standards for treatment of CFS, and existing treatments have not been consistently shown to be effective. Legitimate treatment for CFS is limited to relieving individual symptoms, such as prescribing medications for headaches or muscle pains.
- **Cosmetic, plastic or reconstructive surgery**, except as described in the "Plastic or Reconstructive Surgery" section of the "What's Covered?" chapter.
- **Counseling services**: TRICARE Standard doesn't cover nutritional counseling, diabetic self-help counseling, diabetic self-education programs, stress management, life-style modifications, marriage counseling (marriage counseling isn't the same as treatment by a marriage and family therapist, which ***is*** covered under TRICARE

Standard), etc. Counseling services may be covered under the expanded preventive care benefit, as long as they are performed in connection with immunizations, pap smears, mammograms, or examinations for colon and prostate cancer. However, they are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

- **Custodial care** in an institution or home. Custodial care is taking care of someone's daily needs, such as eating, dressing or providing a place to sleep, as opposed to taking care of someone's medical needs. Some aspects of the care may be covered, such as limited specific skilled nursing services (one hour per day), prescription medicines and up to 12 physician visits per calendar year. Medically necessary care for an inpatient in an acute-care hospital is covered, even if the person's condition is considered "custodial." This can be a gray area, so check with your HBA, BCAC, or TSC if you have questions.
- **Dental care and dental x-rays**, except as provided in the "Dental Care" section of the "What's Covered" chapter.
- **Education or training**, except under the Program for Persons with Disabilities.
- **Electrolysis**
- **Experimental procedures** (also referred to as "unproven" procedures)
- **Eyeglasses and contact lenses**, except under very limited circumstances, such as corneal lens removal.

- **Food, food substitutes or supplements, or vitamins outside of a hospital**, except for home parenteral nutrition therapy, such as prescribed for cancer patients.
- **Foot care**, except when there's a medical problem or injury.
- **Genetic tests** not ordered by a doctor and under certain other conditions. (See the "Having a Baby" section of the "What's Covered?" chapter and check with your HBA, BCAC, or TSC.)
- **Hearing aids**, except under the Program for Persons with Disabilities. (See the chapter titled "Program for Persons with Disabilities.")
- **Hearing examinations**, unless in connection with surgery or some medical problem, or under the Program for Persons with Disabilities. But there are hearing examinations under the well-child care benefit.
- **Learning disabilities**, such as dyslexia.
- **Megavitamins and orthomolecular psychiatric therapy**
- **Mind expansion or elective psychotherapy** (for example, Erhard Seminar Training (EST), transcendental meditation and Z-therapy).
- **Orthodontia**, except in limited cases, such as when related to the surgical correction of a cleft palate.
- **Orthopedic shoes and arch supports**, except when part of a brace.
- **Over-the-counter drugs**—those not requiring a prescription by a physician. TRICARE Standard does not share the

cost of drugs available without a prescription, even if a physician does write a prescription for such drugs.

- **Private hospital rooms**, unless the doctor orders it for medical reasons, or a semi-private room is not available. Hospitals that are subject to TRICARE's diagnosis-related groups (DRG) payment system may provide the patient with a private room, but will still only receive the standard DRG amount. If a patient asks for a private room, the hospital can bill the patient for the extra charges.
- **Rest cure**
- **Retirement homes**
- **Self-help courses, relaxation**: TRICARE Standard doesn't cover self-help courses, items or charges related to exercising or relaxation, such as spas, whirlpools, hot tubs, swimming pools, and the like.
- **Sex changes**
- **Speech therapy**, except when related to a specific illness or injury.
- **Sexual inadequacy treatment** (the prescription medication called Viagra ***is*** covered, within certain limits, if it's determined by a patient's physician to be medically necessary for treatment of a TRICARE-covered medical problem)
- **Surgical sterilization reversals**
- **Telephone services or advice** (except in TRICARE regions), including remote monitoring and consultation, except for trans-telephonic monitoring of pacemakers. Other types of diagnoses or monitoring by telephone may

be available. Check with your HBA, BCAC, or TSC for details.

- **Weight control** or weight reduction services and supplies are not covered, except for certain surgical procedures when specific conditions have been met. (See "Obesity Treatment" in the "What's Covered?" chapter for details.)
- **Workers' compensation**: TRICARE Standard will not cost-share work-related illnesses or injuries that are covered under workers' compensation programs.

Medical Review

A national medical review organization is under contract to TRICARE to review some types of care received by eligible patients before TRICARE shares the cost of that care. The care that's reviewed includes inpatient care that falls under TRICARE's diagnosis-related groups (DRG) payment system. Outpatient care may also be evaluated. The review organization makes sure the care is reasonable, necessary and appropriate.

Physicians and hospitals are generally familiar with, and are required to participate in, a TRICARE contractor's medical review program.

If you have any questions about whether medical review applies to your care, check with your physician or hospital.

Special rules apply in situations where review organizations evaluate care. Requests for reconsideration of review decisions should be submitted directly to the review organization, following the appeal instructions contained in the initial determination letter to you.

In areas where the full TRICARE program is in operation, the TRICARE contractors handle reviews of medical care.

Where to Get Care

Try to Use a Service Hospital to Save Money

If possible, try to get your health care from a military medical facility. If you live in certain ZIP code areas around a service hospital, you must try to get inpatient care from that hospital first, except in a true medical emergency, or when you have other, non-TRICARE, major medical insurance. Some outpatient care may also require pre-authorization. Check with your nearby military medical facility, or your TRICARE contractor, before getting any type of care.

Using a military hospital instead of TRICARE Standard saves you money and paperwork. So, check with your HBA to find out if the hospital can care for you.

Even if you live far away from a military hospital, it can still cost you less to get care there. This is especially true for expensive major procedures. The transportation to and from the military hospital could cost you much less than your cost-share under TRICARE Standard. And in some cases, the uniformed services may be able to assist with transportation. Check with your HBA, BCAC, or TRICARE Service Center (TSC).

Who Has Priority for Care at Service Hospitals?

Call ahead to the military hospital to see if you can be treated there. Patient priorities in these hospitals changed in August 1996, so that persons who are enrolled in TRICARE Prime will be seen first. While you may be eligible for care, there may not be space available.

Here's the order of priority for health care in military medical facilities, as established by the Assistant Secretary of Defense for Health Affairs:

1. **Active duty service members.**
2. **Active duty family members *who are enrolled in TRICARE Prime* (for the purpose of determining access priority, survivors of military sponsors who died on active duty *who are enrolled in TRICARE Prime* are included in this priority group).**
3. **Retirees, their family members and survivors *who are enrolled in TRICARE Prime*.**
4. **Family members of active duty service members *who are NOT enrolled in TRICARE Prime* (for the purpose of determining access priority, survivors of military sponsors who died on active duty, who are *not* enrolled in TRICARE Prime, are included in this priority group).**
5. **All other eligible persons.**

Note: There are certain special provisions in the military hospital access policy, as follows:

- Military members who are not on active duty, but who are entitled to care in a service hospital, are in Priority Group 1. This includes members of reserve components entitled to medical care relating to conditions incurred in the line of duty, and members on the Temporary Disability Retired List for required periodic medical examinations.
- NATO and other foreign military members who are entitled to care in a military medical treatment facility, pursuant to an applicable international agreement are in Priority Group 1, for the scope of the services specified in the agreement.
- NATO and other foreign military members' family members who are entitled to care, pursuant to an applicable international agreement, are in Priority Group 2, for the scope of services specified in the agreement.
- As indicated in the priority list above, survivors of sponsors who die on active duty, as provided in the law—10 U.S. Code 1076(a)—are, for purposes of access to military hospitals, considered to be together with active duty family members. They would, therefore, be in Priority Group 2 or 4, depending on whether or not they were enrolled in TRICARE Prime.
- Persons other than those in any of the beneficiary groups identified in Priority Groups 1 through 5 don't have priority access.
- Priority access rules are not applicable to bona fide medical emergencies, or cases in which the providing of certain medical care is required by law, or applicable Department of Defense Directive or Instruction. This includes care for

civilian employees who are exposed to health hazards in the workplace or are injured on the job.

In certain situations, military hospital commanders may grant exceptions to the priority access rules. For example:

- A higher priority may be given to an active duty family that's in Priority Group 4 because TRICARE Prime isn't available where the sponsor is assigned, when the family member is temporarily in a location where TRICARE Prime is available, and needs medical care.
- A particular patient might be given a higher priority, if necessary, for the military hospital to maintain an adequate mix of cases for its graduate medical education programs, or to help maintain the readiness-related medical skills of its medical staff.
- A higher priority might be given to a patient in other unexpected or extraordinary cases, as determined by the hospital commander, in coordination with the military lead agent (a military office that oversees contractor operations in a particular region) for the TRICARE region.
- And, in overseas locations, other exceptions may be established to the extent necessary to support mission objectives.

You can get outpatient care from a military hospital free. For inpatient care, you pay only a small amount for each day. This daily fee is usually much less than the daily costs in a civilian hospital. Furthermore, you don't need a nonavailability statement for care at a military hospital and you don't have to file any claims.

If You Live Near a Uniformed Service Hospital, You Must Try It First

If you live in a certain ZIP code area around a military hospital ("catchment area"), you must try to use that hospital for non-emergency inpatient care. Otherwise, TRICARE Standard cannot help pay for any of the care if you get it from civilian sources instead.

The ZIP code zones are specific for each military hospital and are updated periodically. Check with your HBA, BCAC, or TSC if you aren't sure whether your home address falls within the ZIP code zone. (***Note***: Outside the 50 states and Puerto Rico, a 40-mile radius around a hospital is used—not ZIP code zones.)

Important:

For some kinds of highly specialized care such as open-heart surgery, the ZIP code service areas have been expanded to zones of up to 200 miles around particular military hospitals, or even nationwide in extraordinary cases, such as for certain organ transplants. This means that if you need a certain type of specialized care, you may have to try to get the care at a specific military medical facility that may be a considerable distance from your home. This new requirement makes it even more important that you check with your nearest HBA, BCAC, or TSC before seeking care from a civilian source under TRICARE Standard.

Nonavailability Statements

If the military hospital near you cannot provide the inpatient care you need, you must ask them for a nonavailability statement.

A nonavailability statement (NAS) is a certification from a military hospital stating that it cannot provide the care. If you don't get a nonavailability statement before you get inpatient care from a civilian source, TRICARE Standard may not share your costs.

The NAS system is now automated. This means that, instead of paper copies of the NASs being sent in with the TRICARE Standard claim, the uniformed service medical facility enters the NASs *electronically* into the DEERS computer files.

Important Note:

Even though outpatient NASs are no longer required for outpatient procedures (see the Maternity Care section, earlier in this book, for an exception to this), *TRICARE regional contractors may require that* ***all*** *TRICARE-eligible persons—not just those who live within the ZIP code service area (also called a "catchment area") of a uniformed services hospital—****must have some, or all, outpatient procedures approved ahead of time by the contractor****.*

Check with your TRICARE contractor, your nearest TRICARE Service Center (TSC), your Health Benefits Adviser (HBA), or your Beneficiary Counseling and Assistance Coordinator (BCAC) for details on getting

advance authorization to have <u>any</u> procedures done. Providers of care—whether or not they participate in TRICARE Standard—are supposed to get these advance authorizations. If they don't (or won't), you should check with the Health Care Finder (HCF) at your nearest TSC to ensure that the procedure will be covered.

If you live in the ZIP code zone around a military hospital, the only times you ***don't*** need a nonavailability statement for non-emergency inpatient care are:

- **When you have other non-TRICARE Standard major medical care insurance** that pays first on the bills for TRICARE Standard-covered care. (There may be exceptions to this policy for ***outpatient*** care in your TRICARE region. Check with your HBA, BCAC, TSC or TRICARE contractor on this.)

- **In a true medical emergency**. A medical emergency is the sudden and unexpected onset of a medical condition, or the acute worsening of a chronic condition, that is threatening to life, limb or sight, and which requires immediate medical treatment, or which requires treatment to relieve suffering from painful symptoms. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and other acute conditions that are determined to be medical emergencies. Pregnancy-related medical emergencies must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk.

Be sure to check with your nearby military hospital or clinic *every time* you need inpatient care. Even if they couldn't

provide the care you needed the last time you checked, their staffing levels or capabilities may have changed, and they may now be able to care for you.

Remember:

An NAS is valid for a hospital admission which occurs within 30 calendar days after the NAS is issued. It will remain valid from the date of admission until 15 days after discharge for any follow-up treatment that's directly related to the admission.

For ***newborn care***, in the event that a newborn infant stays in the hospital continuously after the mother's discharge, the mother's NAS will remain valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15-day limit, a claim for non-emergency inpatient care requires a valid NAS in the infant's name.

Remember:

Just because a uniformed service hospital gives you a nonavailability statement does not mean that TRICARE Standard can help you pay for all care that you receive from any provider. TRICARE Standard cost-shares only the kinds of care allowed by the TRICARE Standard rules. And TRICARE Standard helps pay for care only from the kinds of providers TRICARE Standard recognizes. These providers are listed below.

Where and From Whom Can You Get Care under TRICARE Standard?

A "provider" is the person, business or institution that provides or gives you health care. For example, a doctor is a provider. A hospital is a provider. An ambulance company is a provider. There are many other types.

TRICARE Standard can help pay for covered services only from the types of providers listed on the next pages.

In addition to being on the list below, providers must be authorized under the TRICARE Regulation, and must have their authorized status verified (certified) by their regional TRICARE contractor. Being authorized usually means that the providers are licensed by their state, are accredited by a national organization and/or meet other standards of the medical community. If a provider is not authorized, TRICARE Standard cannot help pay for care from that provider. Most hospitals and doctors are authorized by TRICARE (check with them, just to be certain). But for other types of providers, it's a good idea to check with your regional contractor, BCAC, or HBA before getting care to make sure they're authorized by TRICARE.

Generally, active duty service members and civilian employees of the federal government are not authorized to be providers of care under TRICARE. So, TRICARE-eligible persons should be careful about seeking treatment from the "outside" practices of federal government medical personnel.

Health Care Centers

- **Hospitals**

- **Christian Science sanatoria**, if part of the First Church of Christ, Scientist.
- **College or university infirmaries**
- **Skilled nursing facilities**, not including retirement homes or homes for the aged or infirm, which are not covered by TRICARE.
- **TRICARE-approved residential treatment centers** for emotionally disturbed children and adolescents.
- **TRICARE-approved special treatment centers**, such as drug and alcohol treatment centers.
- **TRICARE-approved ambulatory surgery centers**
- **TRICARE-approved birthing centers**. Separate approval is required for care at a birthing center, even if the center is otherwise authorized as a provider of care by TRICARE. Check with your HBA, BCAC, or TSC.

Note:

Check with your HBA, BCAC, or TSC before getting care at certain facilities, such as outpatient rehabilitation facilities, birthing centers, pain treatment facilities, mental health clinics, residential treatment centers, and eating disorder clinics. They may not be TRICARE-authorized providers of care, or the services they provide may not be benefits under TRICARE Standard.

Individual Providers

- **Physicians**, including both doctors of medicine (M.D.s) and doctors of osteopathy (D.O.s).
- **Attending physicians**. Another provider of care (podiatrist, clinical psychologist, oral surgeon, etc.) may be treated as an attending physician, as long as he or she is operating within the confines of the scope of practice of that particular discipline. TRICARE's definition of "surgical assistant" has also been expanded to include other authorized individual professional providers. This will allow dentists or podiatrists to assist when the surgery is complex enough to warrant an assistant.
- **Dentists** (D.D.S.s or D.M.D.s)
- **Most clinical psychologists** with Ph.D.s or Psy.D.s
- **Podiatrists** (D.P.M.s)
- **Physician assistants** (P.A.s). Physician assistants must meet applicable certification and licensing criteria, and must be supervised by physicians who employ them and who are themselves authorized providers of care under TRICARE.
- **Certified nurse midwives**
- **Christian Science practitioners** and nurses, if currently listed in the *Christian Science Journal.*
- **Certified clinical social workers** with at least a master's degree in social work from an accredited school of social work, plus two years of post-graduate clinical experience.

- **Certified nurse practitioners** and clinical nurse specialists, if approved by the state in which they work.
- **Certified psychiatric nurse specialists**
- **Certified marriage and family therapists**. Certified marriage and family therapists may be authorized as independent providers of care (that is, they don't require physician referral and supervision) under TRICARE, but only when they sign an agreement with TRICARE. The agreement requires certified marriage and family therapists to accept the TRICARE Standard allowable charge as the full fee for their services (they can't bill the patient separately for charges disallowed by TRICARE Standard or for non-covered services they provide). Therapists who don't sign the agreement may not be authorized by TRICARE as certified marriage and family therapists.

  Remember:

  TRICARE Standard won't pay for marriage and family counseling, but will share the cost of psychotherapy provided by certified marriage and family therapists in the treatment of a valid mental disorder.

- **Optometrists** (O.D.s)

Your doctor may also refer you to someone else for certain services. TRICARE Standard cost-shares covered services from the providers below only if the referring doctor's name is shown on the claim form:

- **Independent laboratories**
- **Radiology services**

- **Pharmacies**
- **Medical equipment and supply firms**

As long as a physician refers you and supervises the care, and other requirements are met, covered services from the providers below can be cost-shared. The name of the physician who referred you and is monitoring the care must be indicated on the claim form:

- **Registered nurses** (R.N.s)
- **Licensed practical nurses** (L.P.N.s)
- **Physical therapists** (P.T.s)
- **Occupational therapists** (O.T.s)
- **Mental health counselors**
- **Audiologists**
- **Speech therapists**
- **Pastoral counselors**

Providers Who Participate in TRICARE Standard Save You Money

Individual providers who "participate" in TRICARE Standard agree to accept the TRICARE Standard "allowable charge" as their full fee for your care. (***Note***: "Accepting assignment" means the same as participating.) The allowable charges for medical services are based on computations made under a method called the "resource-based relative value system" (RBRVS). Your cost-share is based on the allowable

charge—no matter what the provider actually bills you. So with providers who participate in TRICARE Standard (and after your annual deductible has been accounted for), you only pay your cost-share for TRICARE Standard-covered care and charges for any care not covered by TRICARE Standard. (The provider may ask you to pay your cost-share right away or may wait until after TRICARE Standard has paid the claim.)

Providers who do not participate will bill you for their normal charges. The law says that bill may be up to 15 percent more than the TRICARE Standard allowable charge. You arrange with the provider how you will pay the bill. When you file the TRICARE Standard claim, TRICARE Standard pays you its share of the allowable charge. That means you pay your cost-share, and you pay any difference between the allowable charge and the actual bill, up to the legal billing limit. (See the chapter on costs for more information.)

How to Find Providers Who Participate in TRICARE Standard

Individual professional providers of care who have not signed up to be part of a TRICARE Prime or Extra network participate voluntarily in TRICARE Standard. They can choose to participate on a case-by-case basis. That is, they may participate one time and not the next time. Your nearest HBA, BCAC, or Health Care Finder, your contractor or your friends and neighbors who have used TRICARE Standard may be able to tell you of providers who have participated in TRICARE Standard in the past.

Before getting care, call and ask if the provider will participate in TRICARE Standard. Be sure they understand that by "participating" in TRICARE Standard, they are agreeing to accept the TRICARE Standard allowable charge as their ***full*** fee for your care. If the provider isn't familiar with TRICARE or has any questions, tell the provider to call the toll-free phone number of the regional TRICARE contractor. Some contractors have a separate, special phone line for providers. Or the provider can ask to be contacted by the contractor's field representative. He or she can tell the provider the allowable charges for the type of care you need. If the provider doesn't know the contractor's phone number, he or she should check with the nearest HBA, BCAC, or TRICARE Service Center.

Note:

By law, providers may not discriminate against you because of race, color, national origin, religion, sex, handicap or age. If you believe you've been discriminated against, contact your HBA, BCAC, or TSC; or write to the TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

Also Important:

All hospitals that participate in Medicare, and hospital-based health care professionals who are employed by, or contracted to, such hospitals, are required by law to participate in TRICARE Standard for inpatient hospital services related to hospital admissions. But remember that some individual providers of care who see patients in the hospital may ***not*** *participate and may bill separately for their services.*

Note For Overseas Travelers:

If you need medical care while traveling in a country where there's no U.S. military medical facility, contact the nearest U.S. consular office for their recommendations on nearby providers of care. If you're unable to do that, try to identify such providers through local sources such as hospitals or clinics.

If you do happen to be traveling in a country where there's a U.S. military medical facility, try to get care there. If the care you need isn't available there, the facility's Health Benefits Adviser might be able to direct you to the type of health care provider you need.

If you plan to do any traveling outside the U.S., claims for any care you receive while overseas should be sent to the TRICARE contractor for the *area in which you live*.

Refer to the "How to File a Claim" chapter of this handbook for information on where to file claims.

Care for Active Duty Families and Others in Overseas Areas

Military force reductions in Western Europe and elsewhere have resulted in reduced levels of medical services for many areas, particularly those where the numbers of active duty forces no longer are enough to support a military health clinic. Service members and their families, especially those in remote areas, have sometimes had problems getting care.

As part of its TRICARE health program for military families, the Defense Department has established the

TRICARE Overseas Program (TOP). TOP blends many of the features of Defense's stateside TRICARE program, while also allowing for the cultural differences and differing health care practices in other countries. TOP consists of three regions: TRICARE Europe, TRICARE Pacific, and TRICARE Latin America. TOP covers all geographic areas and territorial waters outside the continental U.S., except for Puerto Rico.

In order to ease the overseas active duty family's path to health care, the government has taken several steps:

1. All cost-shares and deductibles are waived for Prime-enrolled active duty families in overseas areas.
2. Prime-enrolled active duty family members who can't get care in overseas U.S. military medical facilities will be able to see TRICARE-authorized local host nation civilian providers of care at no cost, when referred by the Primary Care Manager (PCM) and authorized by the military regional service center. Persons who aren't enrolled in TRICARE Prime will use TRICARE Standard.
3. Where possible, military regional service centers in overseas areas will have written agreements with local host nation civilian providers.

Points of contact have been established throughout overseas areas to assist families and providers with claims filing and payment issues. (See the first chapter in this book, "A Look at TRICARE," for information on how TRICARE works in overseas areas for active duty families and other eligible persons.)

New Choices in Health Care for Military Families

Remember that the changing face of health care for service families in the 21st century means that you have new choices concerning where and how to use your uniformed service health care benefits.

As we noted at the beginning of this book, the military health care system is still evolving, and you're likely to encounter more refinements in it over the next several years. Meanwhile, in today's military health care environment, some or all of the three-option TRICARE managed-care program is available to military families nationwide. (See the section in the front of this book on TRICARE Prime and TRICARE Extra for more details about the TRICARE health care options.)

As noted earlier in this book, TRICARE offers the following choices:

1. You may use **TRICARE Standard** (formerly known as CHAMPUS), which is the program described in this section of the handbook.

2. You may use **TRICARE Extra**, which features providers of care who are part of an organized network (often known as a "preferred provider organization," or PPO), and who have agreed to participate in TRICARE for all eligible patients. They'll accept the TRICARE allowable charge (or a negotiated fee) as the full fee for the care they provide and will file claims for you. Your share of the cost of care will be reduced; for example, an active duty family's normal 20 percent cost-share under TRICARE Standard is reduced to 15 percent under TRICARE Extra. You don't have to enroll, and

you may jump back and forth between this option and TRICARE Standard, as you desire.

3. You may enroll in **TRICARE Prime**, which is a health maintenance organization (HMO)-type option. Under this plan, which is currently the least-costly health care option, you must get all of your care from the providers of care in the organization, for as long as you're enrolled. Your care is managed through a Primary Care Manager (PCM) whom you select or to whom you are assigned. Your PCM initiates, and the Health Care Finder (HCF) authorizes, all specialty referrals according to TRICARE contractor policies. There are no deductibles or cost-shares; instead, you may pay an annual enrollment fee, and small pre-set fees (also called co-payments) whenever you visit a clinic, see the doctor, or get a prescription. There are additional health care benefits, such as some preventive medicine services, that aren't covered under TRICARE Standard. And, there are no claims to file.

"Designated Providers": A Defense Department managed-care program called the Uniformed Services Family Health Plan (USFHP) is also available to some eligible persons—including those who are age 65 and older—who live near selected civilian medical facilities around the country. These facilities are called "designated providers" (DPs)—formerly known as Uniformed Services Treatment Facilities (USTFs).

At the hospitals named as DPs, the USFHP provides TRICARE Prime benefits and cost-shares for eligible persons who enroll—including those who are Medicare-eligible.

USFHP's TRICARE-like benefits do not include the "point-of-service" option, under which TRICARE Prime enrollees can get non-emergency care outside their Prime network without their Primary Care Manager's authorization, but pay higher cost-shares and deductibles for the privilege. All care for a USFHP enrollee that's going to be cost-shared by the government must be received from his or her "home" DP, unless the enrollee is traveling (see more about transferring your enrollment to a second DP or TRICARE region below).

Enrollees must live in specific ZIP code service areas around one of the designated hospitals. They may not seek care at military hospitals, or under TRICARE at other civilian medical facilities, during the period of enrollment. Medicare-eligible enrollees must also agree not to use their Medicare benefits for services covered under TRICARE Prime.

The dependents of active duty service members may enroll in the USFHP at any time. Military retirees and their eligible family members may enroll during annual open-enrollment periods, which run for 60 days before the beginning of each TRICARE contractor's option period (the next one-year period of their contract to run the TRICARE program in a given region). The beginning dates of option periods vary by region, so check with your regional TRICARE contractor.

As in TRICARE Prime, non-active duty USFHP enrollees must pay an annual enrollment fee of $230 for one person, or $460 for a family. There's no enrollment fee for active duty family members. And, the enrollment fee is waived for persons who are enrolled in Medicare Part B.

USFHP enrollments are "portable." You can transfer your enrollment to another area twice during your enrollment year—

as long as the second transfer is back to the DP at the site of your original enrollment. Non-Medicare enrollees may transfer from their home DP to another DP—or to an area where TRICARE Prime is offered, and become Prime enrollees for the duration of their stay at the new location. Medicare-eligible USFHP enrollees may only transfer from one DP to another, and back again.

The DP hospitals and clinics where you can enroll in the USFHP managed-care option are:

- **Sisters of Charity Medical Center at Bayley Seton**, 75 Vanderbilt Ave., Staten Island, NY 10304. Telephone: 1-800-241-4848.
- **Johns Hopkins Medical Services Corp**., 3100 Wyman Park Drive, Baltimore, MD 21211. Telephone: 1-800-808-7347.
- **Brighton Marine Health Center** (in conjunction with St. Elizabeth's Medical Center, in Boston), 77 Warren St., Brighton, MA 02139. Telephone: 1-800-818-8589.
- **Martin's Point Health Care Center**, P.O. Box 9746, Portland, ME 04104-5040. Telephone: 1-888-674-8734.
- **Fairview Health System**, 18101 Lorain Ave., Cleveland, OH 44111. Telephone: 1-800-662-1810 (Ohio only); or (216) 476-2534.
- **PacMed Clinics**, 1200 12th Ave. South, Seattle, WA 98144. Telephone: 1-800-585-5883.
- **Sisters of Charity Health Care System**: St. Mary Hospital in Port Arthur, Texas, with additional service to eligible

persons in the Galveston area; St. John Hospital in Nassau Bay, Texas; and St. Joseph Hospital in Houston, Texas. Address: P.O. Box 924708, Houston, TX 77292-4708. Telephone: 1-800-678-7347.

You can find out more information about each of these designated providers on the Internet, at the USFHP Web site, at: **www.usfhp.com**.

Note:

If you enroll in TRICARE Prime and later move away from that contractor's managed care area to a different TRICARE region, and you wish to maintain your Prime enrollment in the new area, you may transfer enrollment when you reach your new location. If you don't want to stay in Prime, you may disenroll at your "old" location before you leave. Check with your HBA, Health Care Finder (HCF) or TRICARE Service Center (TSC) for more information.

Also, in another expansion of government health care resource sharing, some Department of Veterans Affairs (VA) medical centers have become TRICARE-authorized providers of care. They provide limited outpatient and inpatient medical and surgical care to TRICARE-eligible persons who live in their areas. The hospitals have coordinators who serve as Health Benefits Advisers and Health Care Finders for TRICARE-eligible families. Call your nearby VA medical center to find out if it is a TRICARE-authorized provider.

How Much Will It Cost?

TRICARE Standard cost-shares only certain medical bills. You pay the full bill for any care that is not covered by TRICARE Standard.

And for care that is covered, you still pay for part of the bills. How much you pay (your "cost-share") depends on:

- Whether (and where) you get care as an outpatient or inpatient. "Outpatient care" is what you receive when you don't need to stay 24 hours or longer in a hospital or other health care center. "Inpatient care" is what you receive when you're admitted to a hospital or health care center with the reasonable expectation that you'll occupy a bed and will remain in the institution for at least 24 hours;
- Whether the provider participates in TRICARE Standard;
- Your sponsor's status with the service. Active duty families pay a different share than retirees, their families and families of service members who have died, and eligible former military spouses. (See the exception to this at the beginning of the "Who's Covered?" chapter.)

Remember:

It's your responsibility to arrange to pay the provider your portion of the bills. The provider may want you to pay part—or even all—of the cost before you get care.

The Law Limits How Much You Can Be Charged

Certain health care providers who see TRICARE patients but who don't "participate"—also known as "accepting assignment"—in the program are limited by federal law in how much they can charge TRICARE patients for the services they provide.

Non-participating providers may charge no more than 15 percent above the TRICARE maximum allowable charge for their services.

Providers who do participate in TRICARE accept the TRICARE maximum allowable charge as the ***full*** fee for the care they render.

The billing restriction for non-participating providers is contained in Section 9011 of the Department of Defense Appropriations Act of 1993 (Public Law 102-396), and was effective on Nov. 1, 1993. The restriction has been included in all subsequent Department of Defense Appropriations Acts. The legal limit on charges is the same as that used by Medicare.

TRICARE patients who feel that they've been overcharged by a provider of care, and who can't resolve the situation with the provider, may write a letter of complaint to the TRICARE contractor for their region. The contractor will send the provider a letter that explains the legal requirement and asks that the provider refund any charges in excess of the limits to the patient within 30 days.

A provider who doesn't comply with the refund request may ultimately lose his or her authorization to treat TRICARE patients and to be reimbursed for it by the government. What this means to TRICARE-eligible patients is that they could still

be treated by such a provider, but they would have to pay the full bill for any care they might receive; there would be no government reimbursement of any part of the cost.

Some Medical Costs Are "Capped"

Over the next few pages, we'll be talking about the costs of inpatient and outpatient care under TRICARE Standard. While you're reading this material, keep the following important points in mind. A cost "cap" has been placed on your cost-share—that is, on how much you have to pay—for TRICARE Standard-covered medical bills in each fiscal year (Oct. 1 through the following Sept. 30). The limit, or "cap," on cost-shares for each fiscal year is $1,000 for active duty families and $7,500 for all other TRICARE Standard-eligible families.

The cap applies only to the amount of money required to meet your family's annual deductibles and cost-shares based on TRICARE Standard allowable charges for covered medical care received in any one fiscal year. You must pay any charges, up to the legal limit, in excess of those TRICARE determines to be reasonable, or "allowable," for covered care. You must pay all charges for treatment not covered by TRICARE, such as acupuncture, for example. Likewise, any costs you pay under the TRICARE Standard Program for Persons with Disabilities are not counted toward the cap.

Keep track of how much you pay in annual deductibles and cost-shares in a fiscal year. The best way to keep track of medical expenses that count toward meeting the cap is to keep a copy of your TRICARE Standard Explanation of Benefits (EOBs), which is provided with each claim that is processed.

TRICARE contractors also keep track, and when your family's deductibles and cost-shares in a given fiscal year add up to the cap amount, TRICARE Standard will pay the full allowable charges for covered care provided during the rest of the fiscal year.

Remember:

You're still responsible for payment of charges in excess of the allowable charges, up to the legal limit, when you go to a non-participating provider.

For more details on the medical expense cost-share caps, contact your HBA, BCAC, or TRICARE Service Center.

Outpatient Costs

For outpatient care for most families, there is a yearly deductible of $150 for one person or $300 for a family. That is, you pay your provider(s) the first $150 (or, for a family, $300) worth of TRICARE Standard allowable medical bills in a fiscal year. The deductible for family members of active duty E-4s and below is $50 for an individual and $100 for the entire family.

After the deductible is met, active duty families pay 20 percent of the TRICARE Standard allowable charge for each medical bill (except for ambulatory surgery centers, free-standing birthing centers and hospital-based birthing rooms, for which the charge is a flat $25) and all others pay 25 percent. If a health care provider who does not participate in TRICARE Standard bills you for more than the allowable charge, you also

pay the additional amount, up to the legal limit of 15 percent above the TRICARE Standard allowable charge.

The allowable charge is the maximum amount TRICARE Standard will pay for care given by physicians and other providers. It's determined by comparing the actual billed charges, the prevailing charges (what most providers have been charging) for a particular service, and a charge arrived at by applying a Medicare-related formula—then using the lowest of the three as the TRICARE Standard allowable charge.

Outpatient Costs With Providers Who Participate in TRICARE Standard

A provider who participates in TRICARE Standard will send in the claim for your care to the TRICARE contractor. TRICARE Standard will send its share of your medical bills directly to the participating provider. You should arrange with the provider how and when to pay your part of the bill.

Note:

A new, simpler claim form for patients, the DD Form 2642 ("CHAMPUS Claim—Patient's Request for Medical Payment") was introduced in 1994. The new form replaced the DD Form 2520, which is no longer used in the U.S. The new form is only half the length of the old form, and doesn't require a provider's signature. Providers who send claims to TRICARE will use the HCFA Form 1500 (for individual providers) or the UB-92 form (for institutional providers, such as hospitals).

The TRICARE contractor knows the allowable charge for the TRICARE Standard-covered care you receive. The deductible and patient cost-share are subtracted from that amount, unless you have already met the deductible for the year. The claims processor then sends your provider a check for the TRICARE Standard share of the remaining amount.

How Much is Paid?

- For families of active duty service members, the check will be for 80 percent of the remaining allowable amount. You must pay the other 20 percent, plus the deductible if it has not already been paid, to your provider—except for care in ambulatory surgery centers and free-standing birthing centers. (See previous page.)
- For retirees, their families, families of service members who have died, and for eligible former military spouses, the check will be for 75 percent of the remaining allowable amount. You must pay your provider the other 25 percent, plus the deductible if it has not already been paid.

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Here's an example of how this works. Sgt. King is an E-5. His wife, Becky, went to see Dr. Moffett because of stomach pains. Dr. Moffett normally charges $150 for the care Becky received. But Dr. Moffett said he would participate in TRICARE Standard (sometimes also called "accepting TRICARE Standard assignment"), which meant he would accept the TRICARE allowable charge of $100 for the care.

And, he told Becky she could pay after TRICARE Standard had paid its share of the bill.

The TRICARE contractor knew from the files that all of Becky's care was covered and the allowable charge for the care was $100. The files also showed that Becky had already paid her $150 deductible that year. Since Becky was married to an active duty service member, the contractor sent Dr. Moffett a check for 80 percent of the allowable, or $80. The contractor also sent Becky a notice (or "Explanation of Benefits") that Dr. Moffett had received $80 and that she needed to pay Dr. Moffett the remaining $20. So her total cost for the care was $20 (20 percent of the allowable charge of $100).

Outpatient Costs With Providers Who Don't Participate in TRICARE Standard

If your provider doesn't participate in TRICARE Standard, the bill may legally be for up to 15 percent more than the TRICARE Standard allowable charge. And you must arrange payment to the provider for the entire bill, up to the legal limit.

If you're filing the claim, you fill out and sign the DD Form 2642 claim form. Ask your provider for a fully itemized bill. Then send the claim form, and a copy of the bill, to your TRICARE contractor. (See the "How to File a Claim" chapter for a list of contractors.) TRICARE Standard can then pay you what it would have paid the provider, if the provider had participated in TRICARE Standard.

The contractor still uses the allowable charge to figure the TRICARE Standard cost-share for covered care—no matter what the provider charges you. The deductible is subtracted

from the TRICARE Standard allowable charge first; then the cost-share is figured based on the remaining balance, unless you have already paid your deductible for that year. The contractor then sends you a check for the TRICARE Standard portion of the remaining allowable amount.

For families of active duty members, the check will be for 80 percent of the remaining amount, except for care in ambulatory surgery centers or in free-standing birthing centers. (See the "Outpatient Costs " section at the beginning of this chapter.)

For retirees, their families, families of service members who have died, and eligible former spouses, the check will be for 75 percent of the remaining amount. (See the exception for surviving family members at the beginning of the "Who's Covered?" chapter.)

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Here's an example of how this works. Lt. Sorenson's son, Jerry, went to see Dr. Manning because of a swollen finger. Dr. Manning examined Jerry and x-rayed his finger. Dr. Manning said he would not participate in TRICARE Standard, nor would he file the claim for them. He charged Jerry's parents $225.

Dr. Manning wanted to be paid "up front," so the Sorensons paid him $225. They then filled out a DD Form 2642 claim form and sent it to their TRICARE contractor. They included a copy of Dr. Manning's fully itemized bill. Soon, Jerry's parents received a check for $160 from the contractor.

How did the contractor know to pay Jerry's parents $160? The contractor saw from the bill that all of Jerry's care was

covered by TRICARE Standard. The allowable charge for the care was $200. Since Lt. Sorenson was an active duty member, and had already paid the family deductible, TRICARE Standard paid 80 percent of the allowable charge of $200.

Notice that in this case, the Sorensons ended up paying $65 of Dr. Manning's bill for $225. They paid 20 percent of the allowable charge, plus the $25 difference between the allowable charge ($200) and Dr. Manning's bill ($225).

Note also that non-participating providers such as Dr. Manning are limited by law from charging more than 15 percent above the TRICARE allowable charge for the care they provide to TRICARE patients. The extra $25 that Dr. Manning charged in this case is less than 15 percent above the $200 allowable charge, so the Sorensons were legally obligated to pay it.

Inpatient Costs

Care in a hospital is not necessarily inpatient care. Usually, if you stay in a hospital for less than 24 hours, you're an outpatient. If you are admitted to the hospital for an overnight stay (usually 24 hours or more), you're an inpatient. There is no deductible for inpatient care. But, remember, just as for outpatient care, you pay in full for any inpatient care not covered by TRICARE Standard.

Most Hospitals Participate in TRICARE Standard

When the hospital and doctors participate in TRICARE Standard, they usually fill out and send in the claims for both

the hospital's and the doctors' bills. However, you must arrange with them when and how to pay your part of the bills. How much you pay depends on your sponsor's status with the service.

As mentioned earlier, all hospitals that participate in Medicare must, by law, participate in TRICARE Standard as well. *But some individual providers of care who see you in the hospital are not employed by that hospital. These providers may or may not participate in TRICARE Standard. They may bill separately, and may charge more than the TRICARE Standard allowable charge for their services.*

"DRG" Hospital Payment Rules

A few years ago, TRICARE began using a system, similar to that used by Medicare, for paying civilian hospitals for inpatient care. Under the system, called "diagnosis-related groups" (DRGs), most hospitals in the 50 states, the District of Columbia and Puerto Rico are paid a fixed rate for inpatient services, regardless of how much the care costs. Maryland is currently exempt from the DRG payment system because of its stricter state laws.

The DRG amounts paid for inpatient services are based generally on national averages of costs for specific services. The fixed amount that TRICARE Standard pays to a hospital under the DRG system may be either more or less than the hospital charges for a given service.

Note:

Individual doctors' fees for services they provide are not paid by DRG amounts. And, some hospitals even within the so-called "DRG states" are also exempt from DRG payment limits. These hospitals are: psychiatric, cancer, long-term care, rehabilitation hospitals within hospitals, Christian Science sanitaria, and sole community hospitals exempt from Medicare's prospective payment program. The payment system doesn't apply to certain services, such as those provided in exempt psychiatric units or hospitals, solid organ-acquisition costs, certain organ transplants, and children's inpatient cases involving bone marrow transplants, cystic fibrosis, and children who test positive for the HIV (AIDS) virus. Additionally, distinct parts of a hospital providing psychiatric or rehabilitation services would not be affected. In non-DRG hospitals, TRICARE Standard will pay as before.

Families of active duty members pay at least $25 for each admission or a small daily fee for each day in a civilian hospital—whichever total is greater. The daily fee, which is the same charged for inpatient care at military hospitals, changes over time. But no matter how short your hospital stay, you must pay at least $25. TRICARE Standard pays the rest of your covered inpatient bills if all providers participate in TRICARE Standard. (For fiscal year 2000, the daily fee is $10.85; for civilian inpatient mental health care for active duty families, it's $20 per day.)

Retirees, their families, the families of service members who have died, and some former spouses of service members will pay the lesser of 25 percent of the billed charges or a fixed daily amount ($390 in fiscal year 2000). TRICARE Standard will pay the rest of your covered hospital bills.

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Payment for Inpatient Mental Health Care

For inpatient mental health care, the DRG payment system isn't used in certain mental health facilities that are DRG-exempt. Instead, all TRICARE-eligible patients, other than active duty family members, will pay the lesser of the per diem cost-share (that varies according to the facility), or a 25 percent cost-share of allowable charges for institutional services.

Here's an example of how the inpatient cost-sharing system works for an ***active duty family*** without other health insurance: Captain Conrad's daughter, Linda, needed to have her appendix out. Since the Conrads did not live near a military hospital, Linda went to a local civilian hospital.

The hospital was required by law to participate in TRICARE Standard. Linda's surgeon, Dr. Miller, also agreed to participate. This means that they agreed to accept the TRICARE Standard allowable charge as the full fee for the care they provided.

Fortunately, Linda's operation was simple, and she had to stay in the hospital for only three days. After she went home,

the hospital and Dr. Miller sent Linda's claim forms to the TRICARE contractor.

Hospital and Doctor Both Participate	
Hospital Fee Under Participation:	$1,800.00
Dr. Miller's Fee Under Participation:	$1,200.00
Total:	$3,000.00
Linda's Stay: (Active Duty: $10.85 x 3 Days)	$32.55
TRICARE Standard Pays:	$2,967.45
Linda's Family Pays:	$32.55 + TV Fee

The charge for Linda's covered hospital care under the DRG payment system was $1,800. And the claims processor knew the allowable cost for Dr. Miller's services was $1,200. Linda had stayed at the hospital for three days. Since the daily inpatient fee was $10.85 at the time, the total for three days was $32.55. So, the processor sent a check to Dr. Miller for $1,200, a check to the hospital for $1,767.45, and sent a notice to the Conrads that they owed the hospital $32.55. They also had to pay the hospital for items like the TV in Linda's room that were not covered by TRICARE Standard.

Here's an example of how inpatient cost-sharing works for a retiree: Commander Roberts, a retired Navy officer, needed back surgery. Since he lived in a ZIP code zone near a military hospital, he checked to see if he could have the operation there. The hospital did not have the facilities for such an operation. So, the military hospital filed a nonavailability statement electronically with the DEERS computerized eligibility checking

system, and Commander Roberts found a civilian hospital where he could have the surgery.

The hospital participated in TRICARE Standard for the commander's care. And his surgeon, Dr. Jacobs, also agreed to accept TRICARE Standard payment for his services.

The operation went well, but because of some minor complications, Commander Roberts stayed in the hospital for a week. The hospital and Dr. Jacobs sent the claim forms to the TRICARE contractor. The covered hospital charges came to $10,000. And the doctor's allowable charges were $4,000.

TRICARE Standard paid the DRG-specific amount, which was $9,000, minus the commander's cost-share of $2,500, for a total of $6,500. (Remember that under the DRG payment system, Commander Roberts, as a retiree, would pay the lesser of 25 percent of the hospital's $10,000 bill, which is $2,500, or $390 per day times the number of days (seven) that he spent in the hospital, which comes to $2,730. Since $2,500 is less than $2,730, the smaller amount is all he had to pay.)

So, the contractor sent a check to the hospital for $6,500 ($9,000 minus $2,500) and a check to Dr. Jacobs for $3,000 (75 percent of the doctor's allowable cost). The TRICARE contractor also sent a notice, or Explanation of Benefits, to Commander Roberts telling him that he would have to pay the hospital the other $2,500, and that he would have to pay Dr. Jacobs $1,000 (25 percent of the doctor's allowable charges). Fortunately, Commander Roberts had supplemental insurance to help cover his cost-share.

Inpatient Cost-Sharing for a Retiree	
Hospital Bill:	$10,000.00
Surgeon's Fee:	$4,000.00
TRICARE Standard Share of Hospital Bill under DRG System:	$6,500.00
TRICARE Standard Share of Surgeon's Fee:	$3,000.00
Cmdr. Roberts' Share of:	
Hospital Bill	$2,500.00
Surgeon's Fee	$1,000.00

Note:

Because the DRG amount is based on national average costs, the TRICARE Standard amount for hospital care sometimes might be more than a particular hospital charges for a certain type of care. In the example above, the TRICARE Standard DRG rate for the care might be, say, $11,000 instead of $9,000. Even though the hospital's bill for the care was only $10,000, TRICARE Standard would pay the hospital 75 percent of $11,000—or a total of $8,250. Commander Roberts still pays 25 percent of the hospital's billed charges, or $2,500.

Inpatient Costs With Providers Who Don't Participate in TRICARE Standard

It's very rare that a hospital does not participate in TRICARE Standard for inpatient care. If this should happen to

you, contact your Health Benefits Adviser (HBA) or Beneficiary Counseling and Assistance Coordinator (BCAC) for help.

Remember:

All hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient services related to hospital admissions.

But be aware that just because a civilian hospital participates does not mean that the doctors or other providers of care (such as anesthetists) who treat you at that hospital will. The hospital may participate while some doctors or other providers may not, because they are not employees or contractors of the hospital.

Remember, if the doctor doesn't participate, the bill may be for more than the TRICARE Standard allowable charge. You arrange with the doctor how and when to pay the bills.

If the provider of care doesn't participate in TRICARE Standard and refuses to file the claim, you may have to fill out and file the claim form. Get a fully itemized bill. Then sign and send the claim form and a copy of the bill to your TRICARE contractor. TRICARE Standard can then pay you what it would have paid the doctor had the doctor participated in TRICARE Standard. (See the section titled "Fully Itemized Bills" in the "How to File a Claim" chapter.)

For families of active duty members, TRICARE Standard pays the allowable charge. You pay anything over that, up to the legal limit of 15 percent above the TRICARE maximum allowable charge.

For retirees, their families, some former spouses, and the families of service members who have died, TRICARE Standard pays 75 percent of the allowable charge for the doctors' services. You pay 25 percent plus anything over the allowable charge, up to the legal limit. (See the exception for this category of eligible persons at the beginning of the "Who's Covered?" chapter.)

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Other Health Insurance

If you have other health insurance in addition to your TRICARE Standard benefits, TRICARE Standard pays after all other plans you may have, except for Medicaid (a public assistance program), benefits under a State Victims of Crime Compensation Program, and certain insurance policies that are specifically designated as **TRICARE supplements (**these policies are designed to reimburse out-of-pocket expenses that you incur after a TRICARE claims has been processed, and after TRICARE has paid its share of the costs of care).

This means that if you have another health plan in addition to TRICARE Standard, the other plan must pay whatever it covers before TRICARE Standard will make any type of payment. You may have coverage for yourself and your family through an employer, an association, or a private insurer. This also includes the medical portion of an auto insurance policy, or any coverage that students in the family may have through their schools.

When your other plan has paid, then TRICARE Standard will pay for covered outpatient services, within certain limits. Here are two examples of how the government determines its payment for your covered civilian health care (both examples assume that you have already satisfied your annual outpatient deductible):

First Example:

If you go to a provider of care who *participates* in TRICARE Standard, the TRICARE contractors will pay the *lesser* of:

1. The amount of the provider's billed charges, *minus* the other health insurance's payment; *or*
2. The amount that TRICARE Standard *would* have paid if you didn't have any other primary health insurance.

Here's an illustration of the above example: *The participating doctor bills you $100, which is the same as the TRICARE Standard allowable charge for the care. Your other insurance pays $80, leaving $20 unpaid. Since you're a military retiree, the TRICARE Standard share of the doctor's bill would be $75 if you didn't have other insurance. Since you* ***do*** *have other insurance, TRICARE Standard will pay whichever amount—$75 or $20—is less. So, in this illustration, TRICARE Standard pays the $20 that your other insurance didn't cover.*

Second Example:

If you go to a *non-participating* provider—one who does not accept the TRICARE Standard allowable charge as the full

fee for the care provided, and may charge more for your care—the TRICARE contractors will pay the *lesser* of:

1. An amount up to 15 percent *more* than the TRICARE Standard allowable charge, *minus* the amount your other health insurance paid; *or*

2. The amount that TRICARE Standard *would* have paid if you didn't have any other health insurance.

Here's an illustration of the second example: *Although the allowable charge for the care is $100, the non-participating doctor bills you $150. Your other insurance pays $125 of that, leaving $25 unpaid. The TRICARE Standard share of the doctor's bill would be $75—that is, 75 percent of the allowable charge—if you didn't have other insurance. Since you* ***do*** *have other insurance, and it paid $125, TRICARE Standard will pay nothing.*

Why? Because the TRICARE Standard payment for care received from a non-participating provider, when you have other insurance, is limited to 15 percent above the allowable charge (in this case, $115), minus the amount your other insurance paid (in this case, $125). Since the other insurance paid ***more*** *than $115, TRICARE Standard won't pick up any of the rest of the charges.*

Of course, you are responsible for any unpaid amounts the provider has not been paid for TRICARE-covered services, but only up to the legal limit of 15 percent above the allowable charge. In the second illustration (above), the non-participating provider has been paid more than 15 percent above the $100 allowable charge, so you would owe nothing. In this illustra-

tion, you would not be legally liable for more than $115 in medical bills.

You must, however, pay all charges for care that aren't covered by TRICARE Standard.

For ***inpatient*** care in hospitals subject to the TRICARE Standard DRG payment system, payments will be limited to the DRG amount or whatever part of it remains after your other health plan has paid everything it's going to pay.

Sometimes your other plan will pay your entire claim, leaving nothing for TRICARE Standard to pay. *You should still have the claim submitted to your TRICARE contractor*, even though TRICARE Standard won't pay anything if the other plan paid the whole bill. This will ensure that the amounts paid by the other plan are counted toward your TRICARE Standard deductible, so you won't be charged the full deductible on other claims you submit to TRICARE. It will also help ensure that the amounts paid by the other plan are counted toward the cost cap explained at the beginning of this chapter.

Or, the other plan may pay nothing if it doesn't cover the care you received. You still must have the claim filed with your other plan first, and get an Explanation of Benefits from them, which must be sent in with your TRICARE Standard claim. Then, TRICARE Standard will process your claim and pay its share of your care that's covered under TRICARE Standard.

TRICARE-eligible persons who also have medical coverage through an HMO may have TRICARE Standard cost-share expenses under the same rules as for other health plans that pay before TRICARE Standard.

***Caution**: Families who have an HMO (health maintenance organization) as their other health insurance can't jump between the HMO and TRICARE Standard. All covered health care services must be obtained from the HMO.*

When TRICARE Pays Incorrectly

Sometimes, in the processing of more than 25 million claims a year, TRICARE contractors inadvertently overpay claims. The overpayment might go to the patient or to the health care provider, depending on who submitted the claim or on whether or not the provider agreed to participate in TRICARE Standard on the claim.

TRICARE contractors might also overpay if:

- They mistakenly share the cost of care under TRICARE Standard for someone who isn't TRICARE-eligible.
- They pay for care that was given by a provider who wasn't authorized to treat TRICARE patients.
- A claim is submitted—and paid by the TRICARE contractor—that bills for services that were not provided to a patient, or that bills twice for the same services, or that bills for services that are not a benefit under TRICARE.

When any of these things happens—no matter whose fault the incorrect payment was—the TRICARE contractor must take action to get the money back from the person or organization who received the erroneous payment. That's called "recoupment," and it's done to help ensure that your tax dollars are spent properly, according to the law.

Here's what will happen: The contractor will send a written request for repayment of the amount in question. The request will also explain all of your rights under the law, including any right you may have to appeal the denial of TRICARE benefits, and all actions that the contractor may take to get the money back. You should respond to a repayment request within 30 days after you've received it.

Important: Do not ignore a letter that asks you to repay money that was wrongly sent to you. Answer it promptly.

If the overpayment wasn't your fault, the TRICARE contractor will make every effort to help you get your debt repaid. If you can't afford to pay the money all at once, you may be able to make monthly payments. You'll be asked to complete a financial statement, and—depending on your situation—the TRICARE contractor may consider reducing the debt or waiving collection altogether.

If you ignore the letters asking for repayment, any of several things could happen:

1. The amount could be subtracted from any money you might have coming from future TRICARE Standard claims.
2. The TRICARE contractor may take legal action against you, as permitted by state law.

Emergency Room Charges

TRICARE cost-shares emergency room charges on an inpatient basis when the intent was to admit the patient to the hospital once his or her condition was stabilized in the emer-

gency room, but the patient died before being formally admitted. The change from outpatient to inpatient cost-sharing in this situation means that TRICARE begins paying with the first dollar of medical bills, instead of waiting until the family has satisfied the annual outpatient deductible.

How to File a Claim

Do You Have Other Insurance?

Are you covered by other health insurance (OHI)—maybe through your husband or wife, maybe through a job, or under medical coverage for accidental injuries under your automobile insurance policy? If so, you or your provider must file a claim for your health care with the insurance plan before filing with TRICARE Standard. After your other health insurance has decided what it's going to pay, a claim may be filed with TRICARE Standard. A copy of the other health plan's payment determination, and a copy of the bill, must be sent along with your TRICARE Standard claim.

Some providers, even if they agree to participate in TRICARE Standard, may ask you to file with the other insurance first. Discuss this with them when you arrange to pay your part of the bills. If you have TRICARE Standard supplemental insurance—a policy that's specifically designated to be a supplement to TRICARE Standard health benefits, and is sold by many military associations and some private firms—you don't file with them first. Go ahead and have the claim sent to the TRICARE contractor. Make sure that the name of your insurance and other information about the policy is indicated on the claim form.

If you don't tell the TRICARE contractor about your other health insurance, the claim your provider sends in could be delayed in processing or even denied.

Were You Injured in an Accident?

Were you hurt in a car crash, on the job, or in any other type of accident, such as a slip-and-fall, where someone else may be legally responsible (for example, the other driver or your employer)? If so, they or their insurance may have to pay some or all of the medical bills. You or the provider can file claims with TRICARE right away, but be sure to point out on the claim that another person may be responsible. You'll have to complete and attach DD Form 2527, Statement of Personal Injury—Possible Third Party Liability. It's available from your HBA or from your TRICARE contractor. This will also speed up the processing of your TRICARE Standard claim.

If a TRICARE Standard claim appears to involve an injury, and the Form 2527 is not attached, the contractor will write back, sending a blank "2527" and asking for information on the circumstances of the injury. If you don't provide the information, your claim will be denied. **Don't ignore this form**, even if some of the questions on it don't seem to apply to your situation. Even if your accident wasn't caused by someone else, there may be other insurance available to cover part of the cost. For example, you may have a medical benefit as part of your auto insurance or homeowner's liability insurance, or you may be covered by workers' compensation. Be sure to point out this kind of coverage on your TRICARE Standard claim. If you have insurance that pays ***before*** TRICARE Standard does, the TRICARE contractor will not pay your claim until you provide

evidence of the amount the other insurance paid toward your medical expenses.

When your other insurance has paid, TRICARE Standard will then pay its share of the costs as your secondary coverage. The following types of coverage are primary to TRICARE Standard and must pay before TRICARE Standard does:

1. Workers' compensation.
2. Personal injury protection under your auto insurance policy.
3. Coverage under the no-fault or uninsured motorist provisions of your auto insurance policy.

Are You Registered in the DEERS Files?

If you don't appear in the DEERS database as eligible for TRICARE benefits, TRICARE Standard will deny your claim. (See the end of the "Who's Covered?" chapter for details about DEERS.)

It's Important to Fill Out a Claim Form Correctly

The TRICARE contractors get thousands of claims every day. The claims are computer-processed for speed in paying you or your health care provider. Any mistake, forgotten signature or other missing information can slow down your claim because the contractor may have to call or write back to get the needed information.

Reminder: Whoever submits the claim should be sure to enter the ***military sponsor's*** Social Security number on the claim form.

Which Claim Form to Use

If your doctor files the claim, he or she will generally send in a completed HCFA 1500 claim form. When the hospital files the claim, as it must for inpatient care, it will use the UB-92 claim form.

If you file the claim, you'll have to submit a DD Form 2642 ("CHAMPUS Claim—Patient's Request for Medical Payment"). Be sure to attach a copy of the provider's itemized bill to the claim form.

Form	*Use*
DD Form 2642	For care from doctors and other individual providers; sent in by patient/family.
HCFA 1500	For care from doctors and other individual providers; sent in by provider.
UB-92	For inpatient or outpatient care from hospitals and other institutions. The hospital or other institution completes the UB-92. Outside the United States and Puerto Rico, the DD Form 2520 (the "old" yellow CHAMPUS claim form that was formerly used by patients to file claims) is still used for care from hospitals and institutions.

Where to Get the Form

Many providers already have the CHAMPUS forms on hand. You can also get forms from your Health Benefits Adviser, Beneficiary Counseling and Assistance Coordinator, TRICARE Service Center or TRICARE contractor. Or, you can get claim forms by writing to: TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

What Goes in Along with the Claim?

One or more of the following may need to go in with the claim. If they are not provided to the TRICARE contractor when needed, your claim could be denied or delayed. So read this section very carefully.

When your provider files the claim for your care, you may have to get these papers together for the provider, and perhaps have the nearest military hospital file the nonavailability statement electronically. Be sure to make copies of paper documents and keep the originals for yourself, except the claim form—make sure the original claim form is sent in, and keep a copy for yourself.

All attachments should be sent in with each claim, even if a claim was previously filed for similar services during the same course of treatment.

- **Nonavailability Statement**

  If you live within the ZIP code zone (in Europe or elsewhere outside the 50 states and Puerto Rico, it's a 40-mile radius) around a military hospital, that hospital must file a nonavailability statement electronically with the Defense

Department's DEERS computer files for inpatient care at a civilian hospital (except for emergency care). This includes claims for a doctor's services while you were an inpatient, and for inpatient or outpatient maternity care.

For some highly specialized types of treatment, the ZIP code zone may be much wider (perhaps 200 miles), or even nationwide. Check with your nearest HBA, BCAC, or TRICARE Service Center before getting care under TRICARE, to be sure you've followed the rules for getting an NAS.

Note:

*If you have another health insurance policy that pays **first** for the cost of medical services, you don't have to get a nonavailability statement from the local military hospital.*

Important:

In late 1996, there were significant changes to the rules about when—and for what—you need an NAS. For details about these changes, see the chapter titled "Where to Get Care." Also note the information in the same chapter and in the chapter titled "What's Covered?" about authorizations needed for certain types of care.

- **Statement from another insurance plan**

  If you have other insurance (other than a TRICARE supplement), their statement of how much they paid must be attached to the TRICARE Standard claim. This includes coverage under your auto insurance and workers' compen-

sation. If the other plan doesn't pay, you must provide the exclusion section of their policy or a copy of their denial along with your claim. A denial from an HMO or PPO (preferred provider organization) that states you did not use the available services does not count as an exclusion.

- **DD Form 2527** (personal injury questionnaire)

  If you had to go to a hospital (or have a doctor bill of $500 or more) as a result of an accidental injury, you should complete a DD Form 2527 and include it with your claim. It's a questionnaire about how the accident happened. It's needed to complete the processing of your claim. Get a copy from your HBA, BCAC, or TRICARE contractor.

- **Fully itemized bills**

  Photocopies of fully itemized bills must be sent along with your claim. These must be included even if your other health insurance has made payment and their Explanation of Benefits (EOB) is enclosed.

  A fully itemized bill shows the cost for each service or supply you received.

The bill must be on the provider's stationery. And it must show:

1. Name of the patient.
2. Diagnosis or description of symptoms.
3. Each item of service or supply.
4. Place of service.
5. Number/frequency of each service.

6. Date of care.
7. Charge for each item of service or supply.

Bills for prescription drugs must be on the pharmacy's letterhead or billing form, and must also show:

1. Name of the drug.
2. Strength of the drug.
3. How much of the drug you bought (the number of pills or amount of other medicine).
4. Cost of each drug (except prepaid prescription plans).
5. Prescription number and date prescription was filled (you should also include a copy of the actual prescription that was written out by your doctor).
6. Name and address of the prescribing doctor.
7. Name and address of the pharmacy.

TRICARE will not accept canceled checks or cash register receipts. These are not fully itemized bills.

Always make copies of documents that go in with the claim, and keep the originals of these documents for yourself.

Daily Nursing Notes

If you get care from a private duty nurse, copies of the daily nursing notes must be sent along with your claim. The claim should also show which doctor referred you for private nursing and is supervising the care. This is true for all private duty

nursing care, whether it was at home or in a hospital. (See the "Private Duty or Visiting Nurses" section in the chapter titled "What's Covered?")

Doctor's Prescription

For medical supplies (such as syringes, needles, catheters, ostomy bags, etc.) or medical equipment costing $100 or less (such as crutches), a doctor's prescription must go in with your claim. For durable medical equipment worth more than $100 (such as wheelchairs or respirators), the prescription must spell out the particular type of equipment needed, and why and how long you need the equipment. (See the "Durable Medical Equipment" section in the "What's Covered?" chapter.)

Program for Persons with Disabilities

See the next section for information about what must be sent to the TRICARE claims processor with Program for Persons with Disabilities claims.

Helpful Hints for Filing Claims

1. All receipts should be on (or attached to) 8-1/2" x 11" sheets of paper.
2. Include your sponsor's Social Security Number on all pieces of correspondence and attachments to claims.
3. **Do not highlight information** on documents with a "highlighter" or "magic marker." It is either lost in scanning or blackens the information you want to emphasize. ***Circle*** the information instead.

Where to Send the Claim

Send claims to the TRICARE contractor for the area where you live.

Here are up-to-date (as of early 2000) TRICARE claims filing addresses for U.S. and overseas areas. These addresses may change, so check them before having claims sent in:

- **Alabama**—Palmetto GBA, CHAMPUS Claims,

  P.O. Box 7033, Camden, SC 29020-7033 (resource sharing claims)

  P.O. Box 7034, Camden, SC 29020-7034 (mental health claims)

  P.O. Box 7035, Camden, SC 29020-7035 (active duty claims)

  P.O. Box 7036, Camden, SC 29020-7036 (Program for Persons with Disabilities claims)

  P.O. Box 7037, Camden, SC 29020-7037 (adjunctive dental care claims)

  P.O. Box 7031, Camden, SC 29020-7031 (all other claims)

  Toll-free phone: 1-800-403-3950.

- **Alaska**—Palmetto GBA, CHAMPUS Claims, P.O. Box 870001, Surfside Beach, SC 29587-8701. Toll-free phone: 1-800-930-2929.

- **Arizona** (***except*** for the Yuma area; see California listing for Yuma)—Palmetto GBA, P.O. Box 870026, Surfside Beach, SC 29587-8726. Toll-free phone: 1-800-225-4816.

- **Arkansas** (***except*** a small part of Arkansas in the Naval Hospital, Millington, Tenn., service area)—WPS, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832. The Millington area's address and toll-free phone number are the same as the listing for Alabama.
- **California** (***including*** the Yuma, Ariz., area)—Palmetto GBA, CHAMPUS Claims, P.O. Box 870001, Surfside Beach, SC 29587-8701. Toll-free phone: 1-800-930-2929.
- **Colorado**—Palmetto GBA, P.O. Box 870027, Surfside Beach, SC 29587-8727. Toll-free phone: 1-800-225-4816.
- **Connecticut**—Palmetto GBA, CHAMPUS Claims, P.O. Box 7011, Camden, SC 29020-7011. Toll-free phone: 1-800-578-1294.
- **Delaware**—Same as listing for Connecticut.
- **District of Columbia**—Same as listing for Connecticut.
- **Florida, Georgia**—Same as listing for Alabama.
- **Hawaii**—Same as listing for California.
- **Idaho** (***except*** for the six Idaho counties listed below)—Palmetto GBA, P.O. Box 870028, Surfside Beach, SC 29587-8728. Toll-free phone: 1-800-225-4816.
- **Northern Idaho** (these six Idaho counties only: Benewah, Bonner, Boundary, Kootenai, Latah, Shoshone)—WPS TRICARE-NW, P.O. Box 8929, Madison, WI 53708-8929. Toll-free phone: 1-800-404-0110.

- **Illinois**—Palmetto GBA, CHAMPUS Claims, P.O. Box 7021, Camden, SC 29020-7021. Toll-free phone: 1-800-493-1613.
- **Indiana**—Same as listing for Illinois.
- **Iowa**—Palmetto GBA, P.O. Box 870029, Surfside Beach, SC 29587-8729. Toll-free phone: 1-800-225-4816.
- **Kansas**—Palmetto GBA, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816.
- **Kentucky**—Same as listing for Illinois.
- **Louisiana** (western two-thirds, mainly west of Baton Rouge)—WPS, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832.
- **Louisiana** (eastern third of the state, including Baton Rouge and New Orleans)—Same as listing for Alabama.
- **Maine**—Same as listing for Connecticut.
- **Maryland**—Same as listing for Connecticut.
- **Massachusetts**—Same as listing for Connecticut.
- **Michigan**—Same as listing for Illinois.
- **Minnesota**—Palmetto GBA, CHAMPUS Claims, P.O. Box 870029, Surfside Beach, SC 29587-8729. Toll-free phone: 1-800-225-4816.
- **Mississippi**—Same listing as for Alabama.

- **Missouri (*except*** the St. Louis area**)**—Palmetto GBA, CHAMPUS Claims, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816.
- **Missouri** (the St. Louis area)**—**Same as listing for Illinois.
- **Montana**—Palmetto GBA, P.O. Box 870031, Surfside Beach, SC 29587-8731. Toll-free phone: 1-800-225-4816.
- **Nebraska**—Palmetto GBA, P.O. Box 870027, Surfside Beach, SC 29587-8727. Toll-free phone: 1-800-225-4816.
- **Nevada**—Palmetto GBA, P.O. Box 870033, Surfside Beach, SC 29587-8733. Toll-free phone: 1-800-225-4816.
- **New Hampshire**—Same as listing for Connecticut.
- **New Jersey**—Same as listing for Connecticut.
- **New Mexico**—Palmetto GBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816.
- **New York**—Same as listing for Connecticut.
- **North Carolina**—Same as listing for Illinois.
- **North Dakota**—Palmetto GBA, P.O. Box 870031, Surfside Beach, SC 29587-8731. Toll-free phone: 1-800-225-4816.
- **Ohio**—Same as listing for Illinois.
- **Oklahoma**—Same as listing for Arkansas.
- **Oregon**—Same as listing for Northern Idaho.
- **Pennsylvania**—Same as listing for Connecticut.
- **Rhode Island**—Same as listing for Connecticut.

- **South Carolina**—Same as listing for Alabama.
- **South Dakota**—Same as listing for North Dakota.
- **Tennessee**—Same as listing for Alabama (except for a small part of northern Tennessee near Fort Campbell, Ky., which has the same listing as Illinois).
- **Texas** (***except*** southwestern corner of state that includes El Paso, and the Cannon Air Force Base, N.M., service area ZIP codes that fall in Texas)—Same as listing for Arkansas.
- **Texas** (southwestern corner including El Paso, and Cannon Air Force Base, N.M., ZIP codes that fall in Texas)—Palmetto GBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816.
- **Utah**—Palmetto GBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816.
- **Vermont**—Same as listing for Connecticut.
- **Virginia** (the entire state, ***except*** for some ZIP codes—generally, 20100 through 24485—in the part of Northern Virginia that's located in the Washington, D.C. area; check with your nearest HBA or TRICARE Service Center if you aren't sure whether your ZIP code falls into this category)—Same as listing for Illinois.
- **Northern Virginia** (includes ZIP codes—generally, 20100 through 24485—that are in the Washington, D.C. area; check with your HBA or TRICARE Service Center if you aren't sure whether the ZIP code of your residence falls into this region)—Same as listing for Connecticut.
- **Washington**—Same as listing for Northern Idaho.

- **West Virginia** (the entire state, ***except*** for certain ZIP codes—generally, 25401 through 26866—in Northeastern West Virginia that have been placed in TRICARE Region 1; check with your nearest HBA or TRICARE Service Center if you're uncertain which region your ZIP code falls into)—Same as listing for Illinois.
- **Northeastern Tip of West Virginia** (generally includes ZIP codes from 25401 through 26866; check with your HBA or TRICARE Service Center if you aren't sure whether the ZIP code of your residence falls into this region)—Same as listing for Connecticut.
- **Wisconsin**—Same as listing for Illinois.
- **Wyoming**—Palmetto GBA, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816.
- **Puerto Rico**—WPS, P.O. Box 7985, Madison, WI 53707-7985. Telephone: (608) 259-4847.
- **Europe, Africa, Middle East** (plus active duty members' foreign claims)—WPS, P.O. Box 8976, Madison, WI, USA 53708-8976. Telephone: (608) 259-4847.
- **Canada, Mexico, Central America, South America, Bermuda, West Indies, Pacific area (China, Thailand, Korea, Australia, Japan, etc**.)—WPS, P.O. Box 7985, Madison, WI, USA 53707-7985. Phone: (608) 259-4847.

Note: **If you're a retiree, and are not *living* in an overseas area, but are just *traveling* there, be sure to send your claims to the TRICARE claims processing contractor for the state or region *in which you live*.**

Active duty service members should file claims with Wisconsin Physicians Service (WPS), based on their overseas address.

Active duty service members or their dependents who have been stationed overseas and are traveling in the U.S., but who have not yet signed in at their new stateside duty station, should file claims based on their overseas address.

- **Adjunctive dental claims** (worldwide)—***within the continental U.S***., claims should be sent to the specific TRICARE contractors. ***Outside the continental U.S***., claims (including those for persons traveling outside the U.S., and claims for active duty service members who are under TRICARE Europe) should go to: WPS, P.O. Box 8976, Madison, WI USA 53708-8976. Telephone: (608) 259-4847.

- **Christian Science claims**—Christian Science claims for services should be sent to the TRICARE contractor for a given region.

Abbreviations of the names of TRICARE contractors stand for the following:

- **Anthem:** Anthem Alliance for Health, Inc. Anthem is the main TRICARE contractor for North Carolina, most of Virginia, Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, a small part of Tennessee near the Kentucky border, the St. Louis area in Missouri, and most of West Virginia except for a small part of the northeastern tip of the state near the Washington, D.C., area. Anthem has

subcontracted its claims processing operation to Palmetto GBA. That's why Palmetto is listed for the above states, instead of Anthem.

- **Sierra:** Sierra Military Health Services, Inc. Sierra is the main TRICARE contractor for Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, the District of Columbia, part of Northern Virginia, and a small part of northeastern West Virginia. Sierra has subcontracted its claims processing operation to Palmetto GBA. That's why Palmetto is listed for the above states instead of Sierra.

- **TriWest**: TriWest Healthcare Alliance. TriWest is the main TRICARE contractor for Nevada, Arizona, New Mexico, Colorado, Utah, Wyoming, Montana, North and South Dakota, Nebraska, Kansas, Minnesota, Iowa, Missouri, all of Idaho except the following counties: Benewah, Bonner, Boundary, Kootenai, Latah and Shoshone; and the southwestern corner of Texas that includes El Paso. TriWest has subcontracted its claims processing operations to Palmetto GBA. That's why Palmetto is listed for the above states, instead of TriWest.

- **WPS**: Wisconsin Physicians Service. WPS is a subcontractor which works for the main TRICARE contractors in TRICARE Regions 6 and 11, and which processes claims for those regions. WPS also processes TRICARE claims for overseas areas.

- **FHFS**: Foundation Health Federal Services. FHFS is the main TRICARE contractor for TRICARE Regions 6, 9, 10, 11, and for Alaska and Hawaii. FHFS has subcontracted its

claims processing operations to PGBA for TRICARE Regions 9 and 10, and for Alaska and Hawaii; and to WPS for Regions 6 and 11.

- **Humana**: Humana Military Healthcare Services. Humana is the main TRICARE contractor for Florida, Georgia, South Carolina, Alabama, Mississippi, Tennessee, the eastern third of Louisiana, and a small part of Arkansas near the Naval Hospital in Millington, Tenn. Humana has subcontracted its claims processing operations to Palmetto GBA. That's why Palmetto is listed for the above states, instead of Humana.
- **Palmetto GBA (or PGBA)**: Palmetto Government Benefits Administrators. PGBA is a subcontractor which works for the main contractors in several different TRICARE regions, and which processes TRICARE claims for all regions except Regions 6 and 11.

When the Claim Should Be Sent in

You or your provider of care should send your TRICARE Standard claim forms to the TRICARE contractor as soon as possible after you get care. The sooner your TRICARE contractor gets the claim forms and other papers, the sooner you or your provider will be paid.

Claims must be received by the contractor within one year of the date the service was received—or, in the case of inpatient care, within one year of the date of an inpatient's discharge.

What the Submitter Gets Back and How Long It Takes

If everything is okay with your claim, the contractor should send whomever filed the claim a notice called an Explanation of Benefits (EOB) in about a month. The EOB shows:

- What the provider billed.
- The TRICARE Standard allowable charge at the time of care.
- How much of your annual deductible has been met.
- How much you've paid toward your annual cost cap.
- Your cost-share for the care.
- How much TRICARE paid.

If your provider did not agree to participate in TRICARE Standard and didn't file the claim for you (this means *you* had to file the claim), you (instead of the provider) get a check for the TRICARE Standard cost-share. It's your responsibility, of course, to make sure that the provider's bill is paid.

The EOB also gives the reasons for denying services on a claim.

If the claims processor needs additional information, you may get a phone call or letter. If so, you must get that information to the processor within 35 days of the date of the letter or phone call, or else your claim may be denied.

Keep Copies or Originals of Claims and Papers

Keep a copy of the claim and the originals of all other documents that are sent to TRICARE. Even if your provider files the claim, it's a good idea to keep your own copies.

Suppose your claim forms and papers get lost in the mail? Suppose you have questions about your claim? Suppose you think the contractor has made a mistake with your claim? You will need to have your own copies to support your claim for reimbursement.

Program for Persons with Disabilities

Be Aware of These Important Points

- The Program for Persons with Disabilities (PFPWD) is only for persons who are moderately or severely mentally retarded, or who have a serious physical disability, and who are the ***dependents of active duty members*.**
- Although the PFPWD does not require enrollment (as does TRICARE Prime, for example), you must ***apply and get approval*** before receiving services in order for TRICARE Standard to help pay the costs of care.
- You should check with your nearest Health Benefits Adviser (HBA), Beneficiary Counseling and Assistance Coordinator (BCAC), or TRICARE Service Center (TSC) before requesting benefits under the program.
- The PFPWD benefit is limited to $1,000 per month, except for a sponsor who has more than one family member receiving benefits through the PFPWD. Sometimes, ***not*** using PFPWD benefits for diagnostic and treatment services can save you money. You may instead be able to get these services under the basic TRICARE Standard program, where you may have to pay only a maximum of $1,000 in a fiscal

year (this is the "catastrophic cap" on expenses for active duty families).

- But if you decide to use PFPWD for the needed services, and your costs exceed the $1,000 monthly limit, those amounts in excess of the limit under PFPWD may not be cost-shared by TRICARE Standard under the basic program. Because of this, it is very important to work closely with your HBA, BCAC, or TSC when considering using these benefits. (See the beginning of the chapter titled "How Much Will It Cost?" for details on the catastrophic cap.)
- Enrollment in TRICARE Prime does not affect a person's eligibility to receive services through the PFPWD—however, all requirements of TRICARE Prime, such as using the Primary Care Manager for specialty care referral, must also be met.

Who Qualifies?

The Program for Persons with Disabilities serves persons with two kinds of serious disabilities: persons who have moderate or severe mental retardation, and those who have a significant physical disability.

Remember:

The person must be a dependent of an active duty sponsor.

Public Funds and Facilities Must Be Either Unavailable or Insufficient to Meet the Patient's Disability-Related Needs

In many communities, public funds are available for persons with disabilities. If so, you must get assistance from community sources first. Your HBA or TSC may be able to help you find out about help available in your community.

If public help isn't available or isn't enough, TRICARE Standard helps pay for covered services. But you must include with your request for PFPWD benefits a letter from the proper public official saying why public help is unavailable or insufficient. If you don't know who the right public official is, contact an HBA, BCAC, or your TSC.

Note:

As with the rest of the TRICARE program, all providers of services, supplies and equipment must be authorized. See the section titled "Where and From Whom Can You Get Care under TRICARE Standard" in the "Where to Get Care" chapter.

You Must Apply

Active duty family members, or persons acting on their behalf, who apply for benefits under the TRICARE PFPWD must show that the medical condition qualifies them for the program and that the requested benefits are necessary and appropriate. If your PFPWD-eligible family member is diagnosed with a medical condition requiring care beyond the scope of your nearest uniformed services hospital, talk with the HBA,

BCAC, or TSC to determine whether the family member might be eligible for care under the PFPWD.

All program benefits must be authorized in advance. Contact your Health Benefits Adviser, Beneficiary Counseling and Assistance Coordinator, or TRICARE contractor for guidelines on the type of information required to establish the existence of a qualifying medical condition and to establish the need for the benefits required.

Claims for Pre-Authorized Benefits

All benefits under the program must be authorized in writing by TRICARE before any services, supplies or equipment are received. A copy of the authorization must be attached to the claim form.

For all services and supplies under the PFPWD, individual providers of care must send in the HCFA 1500 claim form; institutional providers will use the UB-92 form. The claims should be sent to the TRICARE contractor for the state where the patient lives.

For general medical care of the disabled person, patients or their family members who must file claims will use the DD Form 2642 (“Patient’s Request for Medical Payment”). Providers will use the forms listed in the preceding paragraph. Anyone under the Program for Persons with Disabilities—no matter what age—is covered for general medical care as described in the rest of this handbook.

If the Active Duty Member is Transferred

You must get new benefit authorizations after you move. Contact the HBA, BCAC, or TSC at the new location to help with this.

Changing Health Care Providers

If you need to change the provider listed on the benefit authorization form, ask for a new benefit authorization.

How Much Will It Cost?

You must pay part of the monthly expenses for the person's care before TRICARE Standard can help. How much you must pay depends on the sponsor's pay grade. The monthly costs are shown in the following chart.

Pay Grade	*Member Pays*
E-1 to E-5	$25
E-6	30
E-7, O-1	35
E-8, O-2	40
E-9, W-1, W-2, O-3	45
W-3, W-4, O-4	50
W-5, O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

One Eligible Person with a Qualifying Disability

After you have paid your share, TRICARE Standard will pay as much as $1,000 a month for Program for Persons with Disabilities benefits. If the costs are more than $1,000 in any month, you must pay the extra.

Two or More Eligible Persons with Qualifying Disabilities

If there are two or more persons with the same sponsor who receive services under the Program for Persons with Disabilities, TRICARE will make sure you won't have to pay any more than you pay for one. TRICARE Standard covers all allowable costs for the second person, as long as you pay your full monthly share for the other disabled person. Check with your HBA, BCAC, or TSC for more information.

Appealing Certain TRICARE Decisions

If you have a dispute with certain decisions made by a TRICARE contractor or by the TRICARE Management Activity (TMA)—formerly known as the TRICARE Support Office, and as CHAMPUS headquarters, or OCHAMPUS—you have the right to ask the TRICARE contractor or TMA to take another look or to get another opinion on the decision.

***Important Note*:** *This chapter describes the TRICARE appeals procedures applicable to the routine processing of TRICARE claims and authorizations for care, and health care provider sanctions, by TRICARE contractors and TMA. However, TRICARE "demonstration" projects and special programs may be in place that alter the appeal procedures described in this chapter. Whatever the situation, a decision that is appealable should include notice of your right to appeal, including the address of the next level of appeal. If you have any questions about your right to appeal after reading this chapter and the specific notice of your appeal rights included on a TRICARE decision, check with your nearest Health Benefits Adviser, Beneficiary Counseling and Assistance Coordinator, TRICARE Service Center, or the TRICARE contractor for your region, for more information.*

The appeal process varies, depending on whether the denial of benefits involves a ***medical-necessity*** determination, a

factual determination, or a provider sanction. All initial and appeal denial determinations include a section that fully explains *how*, *where*, and *by when* you must file the next level of appeal.

Medical-necessity determinations are determinations based solely on:

- Whether the care was medically necessary.
- Whether the *level* of care was appropriate.
- Whether the care was custodial. Or—
- Other reasons related to reasonableness, necessity or appropriateness.

Generally, determinations relating to mental health benefits are considered medical-necessity determinations.

The appeal process for adverse medical-necessity determinations is as follows:

1. A ***reconsideration,*** conducted by the TRICARE contractor for your region.

2. A ***second*** reconsideration, conducted by an independent contractor called the National Quality Monitoring Contractor (NQMC).

3. If services have been provided, a ***hearing*** administered by the TMA Office of Appeals and Hearings, and conducted by an independent hearing officer.

Factual determinations are issued in cases involving issues other than medical necessity. Examples of factual determinations are those involving:

- Coverage issues (that is, whether a service is covered under TRICARE policy or regulation).
- Hospice care.
- The Program for Persons with Disabilities.
- Foreign claims.
- A mix of both medical-necessity *and* factual-determination issues.
- Denial of a provider's request for approval as a TRICARE authorized provider.

The appeal process for adverse factual determinations is:

1. A reconsideration, conducted by the TRICARE contractor for your region.

2. A ***formal review***, conducted by the TMA Office of Appeals and Hearings.

3. If services have been provided, a ***hearing*** administered by the TMA Office of Appeals and Hearings and conducted by an independent hearing officer.

Provider sanction determinations suspend, exclude or terminate providers because of provider fraud, abuse, conflict of interest, or other reasons. Only the sanctioned provider or his/her representative can appeal. The appeal process applicable to provider sanctions is a hearing administered by the TMA Office of Appeals and Hearings and conducted by an independent hearing officer.

If you have any questions about your right to appeal after reading this handbook and the specific notice of your appeal

rights included on a TRICARE decision, check with your nearest Health Benefits Adviser, Beneficiary Counseling and Assistance Coordinator, or your region's TRICARE contractor for more information.

What You Can't Appeal

You can't appeal the amount that a TRICARE contractor determines to be the allowable charge for a particular medical service. You may ask the TRICARE contractor to review the amount of the allowable charge to determine if it was calculated correctly. This is called ***an allowable charge review***, not an appeal.

You can't appeal the decision by TMA or by TRICARE contractors to ask you for more information before action on your claim or other request.

Decisions Relating to Eligibility

You can't appeal decisions relating to your eligibility for TRICARE. Although this issue affects your use of TRICARE, you can't appeal such decisions through TRICARE. The uniformed services decide if someone is eligible for TRICARE and issue ID cards. You must appeal decisions regarding your eligibility through the particular military service involved.

Decisions Relating to the Status of TRICARE Providers

You can't appeal decisions relating to the status of TRICARE health care providers. Although you may want to receive care, or have already received care, from a particular provider, you can't appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes or terminates the provider. The provider in question may appeal in his or her own behalf, however.

Appealing TRICARE Contractor and TMA Determinations

If you disagree about the facts in your case, such as whether your diagnosis was correct or whether you were required to be in the hospital, or if you think there is a mistake in how the law or regulation was interpreted, you can appeal by following the procedures spelled out below.

Appealing Medical-Necessity Determinations

If you disagree with a decision that comes back on the Explanation of Benefits (EOB) or some other decision by the TRICARE contractor for your region:

- Write back to the regional contractor, or to the address specified in the notice of your right to appeal, included in your EOB or other decision. Your letter must be post-marked or received by the regional TRICARE contractor within **90 days** of the date on the EOB or the notice with which you disagree. Be sure to include a copy of the EOB

or notice, as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements, and state that you intend to submit additional information. Send the other documents in when you get them.

- The TRICARE contractor will review the case and will issue a reconsideration decision.

If you disagree with a reconsideration decision, and if notice of your right to appeal identifies the National Quality Monitoring Contractor (NQMC) as the next level of appeal:

- Write to NQMC, making sure your letter is postmarked within **90 days** of the date on the reconsideration decision with which you disagree. If you have them, be sure to include a copy of the notice as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements, and state that you intend to submit additional information. Send the other documents in when you get them. Your request for a second reconsideration should be sent to the address of the NQMC specified in the reconsideration determination.
- The NQMC will review the case and will issue a second reconsideration decision.
- If the amount still in dispute is less than $300, or if you have not received the services, the reconsideration decision by the NQMC is final.

- If you still disagree, and if $300 or more is still in dispute, and if the services have already been provided, you can ask TMA to schedule an independent hearing.

Note: There are "expedited" procedures for appealing decisions denying requests for advance authorization of services and requests for continued stays in institutions. If an expedited appeal is available, the initial and appeal denial decisions will include a section fully explaining how, where and by when to file an expedited appeal.

Appealing Factual Determinations

If you disagree with a decision that comes back on the Explanation of Benefits (EOB), or with some other decision by the contractor for your region:

1. Write back to the regional contractor, or to the address specified in the notice of your right to appeal, that's included in your EOB or other decision. Your letter must be postmarked or received by the regional contractor within **90 days** of the date on the EOB or the notice with which you disagree. Be sure to include a copy of the EOB or notice, as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements, and state that you intend to submit additional information. Send the other documents in when you get them.

2. The TRICARE contractor will review the case, and will issue a "reconsideration decision."

3. If the amount in dispute is less than $50, the reconsideration by the TRICARE contractor is final.

4. If you still disagree, and if $50 or more is in dispute, you can ask TMA for a formal review.

If you disagree with a reconsideration decision, or with an initial determination made by TMA, and if notice of your right to appeal any decision identifies TMA as the next level of appeal:

Write to TMA, making sure your letter is postmarked, or received by TMA, within **60 days** of the date on the notice or reconsideration decision with which you disagree. If you have them, be sure to include a copy of the notice, as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements, and state that you intend to submit additional information. Send the other documents in when you get them. Your request for a formal review should be sent to: TMA Office of Appeals and Hearings, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

TMA will review the case and issue a formal review decision. If either the amount still in dispute is less than $300, or you have not received the services, the formal review decision by TMA is final.

If you still disagree, and if $300 or more is still in dispute, and if the services have already been provided, you can ask TMA to schedule an independent hearing.

Appealing Provider Sanction Determinations

A sanctioned provider may request that TMA schedule an independent hearing.

Requesting a Hearing

When you receive the second reconsideration from the NQMC, or the formal review decision from TMA, denying TRICARE benefits—it tells you the steps for requesting a hearing.

Write to TMA, making sure your letter is postmarked, or received by TMA, within **60 days** of the date on the notice or reconsideration or formal review decision with which you disagree. If you have them, be sure to include a copy of the notice as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements, and state that you intend to submit additional information. Send the other documents in when you get them. Your request for a hearing should be sent to: TMA Office of Appeals and Hearings, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

The hearing is conducted by an independent hearing officer at a location convenient to both the requesting party and the government.

The hearing officer issues a recommended decision. The final decision is issued by either the TMA Director (or designee), or the Assistant Secretary of Defense for Health Affairs.

Be Aware

- Only the patient, the participating provider or a sanctioned provider, the parent of a child under 18, the guardian of a patient who is not competent to act in his or her own behalf, or an appointed representative can appeal. For example, a military sponsor can't appeal the denial of a spouse's claim unless the spouse appoints the sponsor in writing as representative.
- The appealing party must prove that he or she is entitled to TRICARE benefits.
- TRICARE network providers are never parties to an appeal and cannot appeal an adverse decision.
- You must meet the deadlines discussed on the previous pages in this chapter. Your requests must be postmarked or received within the required deadlines. If not, the TRICARE regulation says the decision—the one you want to appeal—is final. If you want to submit additional information, and can't get it submitted within the filing deadline, you still must file your appeal by the deadline, but you can indicate that more information is coming.
- Your appeal must go through a formal review by TMA, or a second reconsideration by the NQMC, before an independent hearing can be held.
- TRICARE cannot pay for any of your costs in making an appeal.
- When part of an episode of care is cost-shared by TRICARE and part is denied, **the whole episode of care** will be reviewed when you appeal.

- For appeal-filing purposes, a postmark is a cancellation mark issued by the U.S. Postal Service (for persons who live overseas and who file appeals, postmarks from other countries don't count). Private mail carriers don't issue postmarks. If your letter requesting an appeal is not postmarked by the U.S. Postal Service, the appeal will be considered filed on the date it is ***received*** by the TRICARE contractor or TMA.
- Filing an appeal by facsimile transmission (fax) is acceptable. An appeal submitted is considered filed on the date it is received by the TRICARE contractor or TMA.

CHAMPVA

Although very similar to TRICARE Standard in terms of benefits, it's important to note that CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) is a separate program, distinctly different from TRICARE Standard.

CHAMPVA is the Department of Veterans Affairs' version of TRICARE Standard, in which VA shares with eligible VA beneficiaries the cost of covered health care services and supplies. Administration of CHAMPVA, including the determination of eligibility, the authorization of benefits, and the processing of claims, is the sole responsibility of the Veterans Affairs Health Administration Center in Denver, Colo. For information, contact:

Veterans Affairs Health Administration Center
300 Jackson St.
P.O. Box 65023
Denver, CO 80206-5023

Toll-free phone: 1-800-733-8387

Tips on Using TRICARE Standard

- Know how to reach the nearest Health Benefits Adviser (HBA), Beneficiary Counseling and Assistance Coordinator (BCAC), or the people at the TRICARE Service Center (TSC) in your area. They're called Health Care Finders (HCFs) or Beneficiary Service Representatives (BSRs). They can help you get the most from your health benefits. Also, learn the location of your local contractor's nearest TRICARE Service Center. (See the section in the back of the book, titled "Uniformed Services Medical Facilities," for listings of uniformed services hospitals and clinics where HBAs may be found.)
- Use uniformed services hospitals or clinics whenever possible. They save you money and paperwork.
- If you live within 40-60 air miles of a military treatment facility, check with the HBA or BCAC there to find out if your home address falls within the hospital's ZIP code zone for health care. If so, you must try to use the service hospital first for any non-emergency inpatient civilian care. If that specific care is not available at the service hospital, you must get a nonavailability statement before using TRICARE Standard—unless you have a private health insurance policy that pays first for medical services. If that's the case, you don't need a nonavailability statement. For certain kinds of highly specialized or very expensive

care, ZIP code zones may be increased in size. Check with your HBA, BCAC, or TSC on this before getting care.

- Certain outpatient procedures must be authorized ahead of time for patients who live in areas where the TRICARE program is in operation. (See the chapter titled "Where to Get Care" for more information.)

- You can save money by going to a doctor or other health care provider who "participates in TRICARE Standard." The HBA/BCAC/TSC/HCF may help you find one. Or ask a provider to participate, and have the provider call the claims processor for information on the allowable charge.

  Remember:

  Providers can participate on a case-by-case basis. (See the definition of "participating provider" in the Glossary.)

- Even if a hospital participates in TRICARE Standard, sometimes the doctors and other providers who care for you there do not. If possible, check on this by phone before you go to get care.

- Check your family's DEERS listings annually to make sure the most accurate eligibility and home-address information is included. Enroll newborn children in DEERS as soon as possible. You can do this at your nearest uniformed service facility's personnel office. Keeping your DEERS files current helps your TRICARE contractor process claims for your family more quickly.

- When you go to get care, have your ID card with you. And discuss how and when to pay your part of the bills. If you

are getting outpatient care and have already paid your deductible for that year, bring the Explanation of Benefits (EOB) showing that.

- If you have to file your own claims, fill out claim forms carefully and neatly to speed payment. Be sure to include both your daytime and evening phone numbers. That way, the TRICARE contractor can call you if there are any problems with the form.
- Don't forget to send a copy of the medical bill and clear copies of any other papers that support the claim form.
- TRICARE Standard claims should go to the TRICARE contractor who serves the area ***in which you live***). Your HBA or TSC can give you the right address and toll-free telephone number. (Also, see the "How to File a Claim" chapter in this handbook for addresses and phone numbers.)
- You'll find it easier to reach the claims processors on the toll-free telephones during "non-peak" hours—that is, from the beginning of work hours until 9 a.m., and from 2:30 p.m. until closing, Tuesdays through Thursdays. Remember, their phones are usually open during work hours for the states where their headquarters are located. They'll also have an automated phone system operating after normal office hours which you can use to get answers to simple questions, check on claims status or request forms.
- Keep copies of all your TRICARE Standard claims and papers, even when your provider sends them in.
- To ensure prompt payment, TRICARE Standard claims should be filed soon after the care is received. Claims must

arrive at the contractor's processing office within one year of the date on which you get care—or, for inpatient care, one year from your date of discharge from an inpatient facility.

- If your contractor asks you for more information on a claim, be sure to respond within 35 days of the request. Otherwise, the claim may be denied. Be sure your sponsor's Social Security Number is on the response, and include a copy of the letter requesting the information.
- Families, including active duty, who use TRICARE Standard often should consider supplemental insurance to cover the cost-share under TRICARE Standard. Your HBA, BCAC, or TSC can direct you to military associations or companies that offer supplemental insurance.
- TRICARE Standard coverage and cost-share terms may be changed by Congress.

For Retirees and Survivors

- Remember, if you're eligible for Medicare (Part A)—either on your own or through your spouse or parent—you aren't covered by TRICARE unless you're under age 65 and Medicare-eligible because you're disabled or you have end-stage renal disease—*and*, you're enrolled in Medicare Part B. (See the note under "Medicare and TRICARE" in the "Who's Covered?" section.)
- If you're 65 and not eligible for Medicare Part A, you must get a "Disallowance Notice" from Social Security. You should send this in with the first claim you submit after the

beginning of the month in which your 65th birthday occurs. Make sure your ID card reflects TRICARE eligibility and that DEERS is updated.

- If you're covered by Medicare, remember that Medicare doesn't cover you outside the U.S.; and because you're eligible for Medicare, TRICARE can't cover you. (Exception: Persons under age 65 who are Medicare-eligible because of disability or end-stage renal disease and who purchase Medicare Part B.) If you'll be outside the U.S., you may want to consider private health insurance.
- You're not covered by the TRICARE Program for Persons with Disabilities. But the survivors of deceased active duty sponsors are covered for the first year after the sponsor's death.
- Because your cost-share is more, it makes even more sense for you to:
  - Use a uniformed services hospital or clinic whenever possible, and
  - Get TRICARE supplemental insurance from a military association or a private company, or buy a "primary" health insurance policy—one which pays before TRICARE does—for your covered health care.

If You Suspect Fraud or Abuse

If something doesn't seem right about your medical bills—perhaps the same item is billed twice, or you've been billed for services you never received, or—

- You think someone is providing inappropriate or unnecessary services, and billing for them, or
- You think someone is providing lower-cost or used equipment while billing for higher-cost or new equipment, or
- A supplier is completing a "certificate of medical necessity" for a physician, or
- A provider is incorrectly reporting diagnoses, procedures, medications, or equipment to get a higher payment, or
- Brand-name prescription medications are being billed for when generic drugs were provided, or
- Individual psychotherapy is billed for when it was group counseling that was actually provided—

Here's what to do:

1. Double-check the billings from your provider of care and the Explanation of Benefits (EOB) you received from your TRICARE contractor. Be sure that the only services listed are ones you actually received.
2. If you can't resolve any problems you find by talking to the provider's billing office (some discrepancies might simply be the result of errors in billing), write to the program integrity unit of your regional TRICARE contractor. Explain what you think the problem is, and include copies of the EOB and any other relevant documents.
3. If you know, or have evidence of, another individual—whether it be a provider of care or a TRICARE-eligible

person—submitting fraudulent claims to TRICARE, write to your contractor.

4. Although cost-shares under TRICARE may vary, it's illegal for a provider to waive those cost-shares. When a cost-share is waived, it may keep you from seeking a much-needed second opinion. Here's an example: *A woman is diagnosed with a terminal disease. Her physician waived her cost-share (the portion of the medical bills she was supposed to pay), and the woman didn't seek a second opinion because she didn't want to pay a share of the second physician's charges. Months later, she found out that she wasn't terminally ill after all. A second opinion could have saved her months of unnecessary worry*. You and TRICARE are partners in the payment of your medical expenses. Report to your regional TRICARE contractor any provider who waives your cost-share.

Millions of tax dollars are lost to fraud and abuse of your health benefits programs each year. Your vigilance and alertness may be able to help bring perpetrators of health care fraud and abuse to justice.

TRICARE Active Duty Family Member Dental Plan

The Defense Department's TRICARE Active Duty Family Member Dental Plan offers comprehensive dental insurance coverage, including orthodontics, to the enrolled families of active duty sponsors in the seven uniformed services. The care is provided by civilian dentists. Claims are filed, either by the dentists or by the families who received the dental care, with the civilian contractor who operates the dental plan for the services.

The plan covers family members worldwide.

The TRICARE Active Duty Family Member Dental Plan is not a TRICARE program. It has nothing to do with any medical care-related dental treatment that may be provided to TRICARE-eligible persons under the TRICARE Standard basic program.

For more information about the TRICARE Active Duty Family Member Dental Plan, contact your nearest military personnel office for questions about enrollment. For questions about benefits and the dental plan, contact your military personnel office or your nearest Health Benefits Adviser. Or, call or write the civilian contractor as indicated below:

Claims Mailing Address

United Concordia Companies, Inc.
FMDP Claims Processing
P.O. Box 898220
Camp Hill, PA 17089-8220

Information/Inquiries

United Concordia Companies, Inc.
Customer Service
P.O. Box 898218
Camp Hill, PA 17089-8218

Toll-free telephone: 1-800-866-8499

To get TRICARE Active Duty Family Member Dental Plan claim forms, contact your Health Benefits Adviser or United Concordia.

***Note*:** In early 2001, this dental plan will be combined with the TRICARE Selected Reserve Dental Plan, to form a new *TRICARE Dental Program (TDP)*. The TDP will feature improved benefits, easier enrollment, and expanded eligibility. The scheduled starting date for the TDP is Feb. 1, 2001. Check with your TRICARE Service Center or your Health Benefits Adviser for details.

Glossary

Accept TRICARE Standard assignment

See "Participate in TRICARE."

Allowable charge

The amount on which TRICARE Standard figures your cost-share for covered care. TRICARE Standard computes the allowable charge using a method called the "resource-based relative value system" (RBRVS). The claims processor can tell a provider the allowable charge amount for specific services or procedures. Also known as the "CHAMPUS Maximum Allowable Charge" (CMAC).

Authorized provider

A doctor or other individual authorized provider of care, hospital or supplier who is licensed by the state, accredited by a national organization, or meets other standards of the medical community, and is specifically listed as being authorized to provide benefits under TRICARE. Regional TRICARE contractors must verify (certify) a provider's authorized status before they can pay for services received from that provider. If a provider isn't authorized, TRICARE can't help pay the bills. (See the "Where to Get Care" chapter for other providers.)

Balance billing

This is when a provider bills you for the rest of his or her charges (the "balance" of the charges), after your civilian health insurance plan or TRICARE has paid everything it's going to pay. Federal law says you aren't legally responsible for amounts in excess of 15 percent above the TRICARE allowable charge.

Beneficiary Counseling and Assistance Coordinator (BCAC)

Persons at military hospitals or clinics, at TRICARE Service Centers, or at military lead agents' offices, who are there to answer questions, help solve your health-care-related problems, and help you get the medical care you need through the military and through TRICARE. Contact a BCAC whenever you have questions on obtaining medical care. But remember—while BCACs can give valuable advice and assistance, they can't guarantee coverage under TRICARE. Your TRICARE contractor must review each claim and make payment determinations in accordance with uniformed service eligibility rules and TRICARE regulations.

Beneficiary Services Representative (BSR)

A person who works at your TRICARE service center, who can provide information about using the three TRICARE options, and help with other matters affecting your access to health care, including appointment scheduling.

BRAC site

A military base that has been closed or targeted for closure by the government's Base Realignment and Closure Commission (BRAC).

Capitation

A fixed amount of money that a managed-care plan gives to a doctor or hospital to care for a patient, no matter what the patient's care actually costs.

Catastrophic cap

A cost "cap" or upper limit has been placed on TRICARE Standard-covered medical bills in any fiscal year. The limit that an active duty family will have to pay is $1,000; the limit for all other TRICARE Standard-eligible families is $7,500. (See the beginning of the "How Much Will It Cost?" chapter for more details about this cap on your medical expenses and for the limitations that apply.)

Claims processor

That's the contractor that handles the TRICARE claims for care received within a particular state or region. Claims processing contractors have toll-free phone numbers, so you can reach them easily if you have questions.

Co-payment

This is a fixed amount you'll pay when you're enrolled in TRICARE Prime and you visit the doctor for some type of medical care (the family members of active duty E-4s and below don't have to make co-payments for their care). Sometimes, the terms "co-payment" and "cost-share" are used interchangeably. However, they aren't the same thing. See the description of a "cost-share," immediately below.

Cost-share

That's the percentage you pay—and the part TRICARE Standard pays—of the allowable charges for care on each claim. Your cost-share depends on your sponsor's status (active or retired) in the service. Your cost-share is paid in

addition to the annual deductible for outpatient care and anything a non-participating provider charges above the allowable charge. The TRICARE Standard cost-share is the difference between the allowable charge and your cost-share.

Deductible

That's the amount you must pay on your bills each year toward your outpatient medical care, before TRICARE begins sharing the cost of medical care. That is, you pay your provider(s) the first $150 for an individual, or $300 for a family, worth of medical bills each fiscal year—from Oct. 1 through Sept. 30 (for the families of active duty members in pay grade E-4 and below, the deductible amounts are $50 for an individual and $100 for a family). The contractor keeps track of your deductible and subtracts it from your claims during the year. How much you've paid toward your deductible is spelled out on the Explanation of Benefits. The deductible is separate from, and in addition to, your cost-share.

DEERS

The Defense Enrollment Eligibility Reporting System (DEERS) is the computerized data bank that lists all active and retired military members, and should also include their dependents. Active duty and retired service members are listed automatically, but they must take action to list their dependents and report any changes to family members' status (marriage, divorce, birth of a child, adoption, etc.), and any changes to mailing addresses. TRICARE contractors check DEERS before processing claims to make sure patients are eligible for TRICARE benefits.

Diagnosis-Related Groups (DRGs)

DRGs are a way of paying civilian hospitals for inpatient care under TRICARE Standard. They're effective in 49 states, the District of Columbia and Puerto Rico. Only Maryland is exempt from the federal DRG payment system. Under DRGs, TRICARE Standard pays most hospitals a fixed rate for inpatient services, regardless of how much the care actually costs. The goal is to cut health care costs for both military families and the government. (See the "Inpatient Costs" section in the "How Much Will It Cost?" chapter for a more detailed explanation of DRGs.)

Explanation of Benefits (EOB)

A statement the TRICARE contractor sends you and the provider who participates in TRICARE Standard that shows who provided the care, the kind of covered service or supply received, the allowable charge and amount billed, the amount TRICARE Standard paid, how much of your deductible has been paid, and your cost-share. It also gives the reason for denying a claim. Sometimes also called the TRICARE Explanation of Benefits (TEOB).

Extra

See "TRICARE Extra."

Fiscal Intermediary (FI)

See "claims processor."

Fraud (and abuse)

Fraud occurs when a person or organization deliberately deceives others in order to gain some sort of unauthorized benefit. TRICARE fraud generally involves billing for services that weren't provided, or billing for a service at a higher rate than is actually justified. Health care abuse

occurs when providers supply services or products that are medically necessary or that don't meet professional standards.

Health Benefits Adviser (HBA)

Persons at military hospitals or clinics who are there to help you get access to the medical care you need through the military and through TRICARE. Contact an HBA when you have any questions on obtaining medical care or using your TRICARE benefit. But remember—while HBAs can give valuable advice and assistance, they can't guarantee coverage under TRICARE. Your TRICARE contractor must review each claim and make payment determinations in accordance with uniformed services eligibility rules and the TRICARE Standard regulation.

Health Care Finder (HCF)

These are health care professionals, generally registered nurses, who help you find needed care. If you're enrolled in TRICARE Prime, they work with your Primary Care Manager (PCM) to locate the specialty care you may require. They can also help with referrals, appointments, nonavailability statements, and interpretation of benefits. Health Care Finders are located at TRICARE Service Centers.

Health Maintenance Organization (HMO)

A health plan to which you pay a fixed premium (and often, small user fees) for an assortment of medical services, usually including primary and preventive care. The HMO employs physicians, therapists, etc., to serve your medical needs.

Managed care

A concept under which an organization (like an HMO) delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of care.

Medically (or psychologically) necessary

Medical (or psychological) services or supplies which are considered appropriate care and are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, mental disorders, or well-child care.

Military hospitals

We use it as shorthand for all uniformed services hospitals including the several former Public Health Service hospitals that are now called "designated providers" under TRICARE. Also, the acronym "MTF" (military treatment facility) is sometimes used to refer to military hospitals. (See "Uniformed services hospitals.")

Nonavailability statement (NAS)

A certification from the uniformed service hospital that says it can't provide the care you need. If you live in certain ZIP codes around a military hospital, you must get a non-availability statement before getting non-emergency ***inpatient*** care at a civilian hospital under TRICARE Standard. Don't forget—TRICARE does not determine eligibility, nor does it issue nonavailability statements. The statements must be entered electronically in the Defense Department's DEERS computer files by your nearby military medical facility. (See the "Nonavailability Statements" section of the "Where to Get Care" chapter for the exceptions to this rule.)

Other health insurance (OHI)

If you have other health care coverage—besides TRICARE Standard or TRICARE Extra or Prime—for yourself and your family through an employer, an association or a private insurer; or if a student in the family has a health care plan obtained through his or her school—that's what TRICARE considers "other health insurance" (OHI). It may also be called "double coverage" or "coordination of benefits." It doesn't include TRICARE supplemental insurance. It also does not include Medicaid. (See the definition of TRICARE supplemental insurance later in this glossary.)

Participate in TRICARE

Health care providers who "participate" in TRICARE, also called "accepting assignment," agree to accept the TRICARE allowable charge (including your cost-share and deductible, if any) as the full fee for your care. Individual providers can participate on a case-by-case basis. They file the claim for you and receive the check, if any, from TRICARE. Hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient care. For outpatient care, hospitals may or may not participate.

Participating provider

See "Participate in TRICARE."

Point-of-service

If you're enrolled in TRICARE Prime, you may choose to get care—*without a referral from your Primary Care Manager*—from a provider who's either inside or outside the TRICARE Prime provider network. If you do this, you'll be getting care under the "point-of-service" option, which has higher costs than TRICARE Prime. For more

details about point-of-service, see the first chapter of this book, titled "A Look at TRICARE." Point-of-service doesn't apply to TRICARE Standard or TRICARE Extra.

Preferred provider organization (PPO)
A network of health care providers who provide services to patients at discounted rates or cost-shares.

Prime
See "TRICARE Prime."

Provider
A doctor, hospital or other person or place that delivers medical services and/or supplies.

Sponsor
The service person—either active duty, retired or deceased—whose relationship to you (spouse, parent, etc.) makes you eligible for TRICARE.

TRICARE Prime
One of the three health care options under DoD's TRICARE managed health care program for military families. TRICARE Prime is the HMO-type option, under which you enroll for a year at a time, and agree to seek health care from the network of health care providers and institutions set up by the TRICARE contractor for the region in which you live. (See the "TRICARE Prime" section at the beginning of this book for more details about Prime, such as how this option works and how much it costs.)

TRICARE Extra

This is the second of the three health care options under DoD's TRICARE managed health care program. You don't have to enroll in Extra; you may use it on a case-by-case basis. You simply see a provider who's part of the TRICARE Extra network established by the local TRICARE contractor, and pay reduced cost-shares for your care. (See the "TRICARE Extra" section at the front of this book for more details about Extra.)

TRICARE supplemental insurance

These are health benefit plans that are specifically designed to supplement TRICARE Prime, Extra or Standard benefits. They generally pay most or all of whatever's left after TRICARE has paid its share of the cost of covered health care services and supplies. These plans are frequently available from military associations and other private organizations and firms. Such policies aren't necessarily just for retirees, but may be useful for other TRICARE-eligible families as well.

Uniformed services hospitals

This includes all military hospitals and former Public Health Service hospitals that were subsequently called "uniformed services treatment facilities" (USTFs), and are now called "designated providers" under TRICARE, in Baltimore; Boston; Seattle; Portland, Maine; Cleveland; Houston, Galveston, Port Arthur and Nassau Bay, Texas; and Staten Island, N.Y.

Uniformed Services Medical Facilities

Note: Because of the various base closings and realignments currently underway or planned, some hospitals may be closed or changed to clinics after this handbook is published. The following list of medical facilities is as complete and accurate as was possible at press time. States or countries that aren't listed have no military medical or dental facilities.

ALABAMA

Medical Clinics:

Fox Army Community Clinic, Redstone Arsenal, AL 35809-7000. Near Huntsville.

Lyster Army Community Hospital, Fort Rucker, AL 36362-5350. Near Dothan.

42 Medical Group, Maxwell AFB, AL 36112-6219. Near Montgomery.

US Army Health Clinic, Anniston Army Depot, Anniston, AL 36205-5083

US Coast Guard Aviation Training Center Clinic, Mobile, AL 36608

ALASKA

Hospitals:

Bassett Army Community Hospital, Fort J. M. Wainwright, Fairbanks, AK 99703-7300

3 Medical Group, Elmendorf AFB, AK 99506-3700. Near Anchorage.

Medical Clinics:

US Army Health Clinic, Fort Greely, Big Delta, AK 96508 (Scheduled to close 6/30/01)

US Army Troop Medical Clinic, Fort Richardson, Anchorage, AK 99505

354 Medical Group, Eielson AFB, AK 99702-2325. Near Fairbanks.

US Coast Guard Base Clinic, Ketchikan, AK 99901

US Coast Guard Support Center, Health Services Clinic, Kodiak, AK 99619

US Coast Guard Air Station Clinic, Sitka, AK 99835

ARIZONA

Hospitals:

Raymond W. Bliss Army Community Clinic, Ft. Huachuca, Sierra Vista, AZ 85613-7040

56 Medical Group, Luke AFB, AZ 85309-1525. Near Phoenix.

Medical Clinics:

355 Medical Group, Davis-Monthan AFB, AZ 85707-4405. Near Tucson.

US Army Health Clinic, Yuma Proving Ground, Yuma, AZ 85365

Naval Branch Medical Clinic, Marine Corps Air Station, Yuma, AZ 85369-5008

ARKANSAS

Medical Clinics:

314 Medical Group, Little Rock AFB, AR 72099-5057

US Army Health Clinic, Pine Bluff Arsenal, Pine Bluff (Mailing address: Reynolds Army Community Hospital, Fort Sill, Lawton, OK 73503-6400)

CALIFORNIA

Hospitals:

60 Medical Group, Travis AFB, CA 94535-1880. Near Fairfield.

95 Medical Group, Edwards AFB, CA 93523-1730. Near Rosamond, north of Los Angeles.

30 Medical Group, Vandenberg AFB, CA 93437-5300. Near Lompoc, northwest of Santa Barbara.

Weed Army Community Hospital, Fort Irwin, CA 92310-5065. Near Barstow.

Naval Hospital, Lemoore, CA 93246-5004

Naval Hospital, San Diego, CA 92134-5000

Naval Hospital, Camp Pendleton, CA 92055-5008. Near Oceanside, north of San Diego.

MCAGCC Twenty-Nine Palms, CA 92278-5008. Near Palm Springs.

Medical Clinics:

Presidio of Monterey, Monterey (Army), CA 93940

9 Medical Group, Beale AFB, CA 95903-1907. Near Marysville, north of Sacramento.

61 Medical Group, Los Angeles AFB, CA 90245-4661

77 Medical Group, Mather AFB, CA 95655-1200

77 Medical Group, McClellan AFB, CA 95652-1074. Near Sacramento.

750 Medical Squadron, Sunnyvale, CA 94089-1234

US Coast Guard Support Center Clinic, Coast Guard Island, Alameda, CA 94501

US Coast Guard Training Center Clinic, Petaluma, CA 94952

US Coast Guard Support Center Clinic, San Pedro, CA 90731-0208

Port Hueneme, CA 93043-5004 (Navy)

NAVSTA, San Diego, CA 92136-5153

MCLB Barstow, CA 92311 (Navy/Marine)

MCMWTC Bridgeport, CA 93517 (Navy/Marine)

Headquarters, Area 13, Camp Pendleton, CA 92055 (Navy). Near Oceanside, north of San Diego.

Del Mar, Area 21, Camp Pendleton, CA 92055 (Navy)

Chappo, Area 22, Camp Pendleton, CA 92055 (Navy)

Base Correctional Fac, Area 24, Camp Pendleton, CA 92055 (Navy)

Edson Range, Area 31, Camp Pendleton, CA 92055 (Navy)

Margarita, Area 33, Camp Pendleton, CA 92055 (Navy)

Las Flores, Area 41, Camp Pendleton, CA 92055 (Navy)

Las Pulgas, Area 43, Camp Pendleton, CA 92055 (Navy)

San Onofre, Area 52, Camp Pendleton, CA 92055 (Navy)

Horno, Area 53, Camp Pendleton, CA 92055 (Navy)

San Mateo, Area 62, Camp Pendleton, CA 92055 (Navy)

NWS, Area 65, Camp Pendleton, CA 92055 (Navy)

NWC China Lake, CA 93555 (Navy)

WPNSTA Seal Beach, CA 90740 (Navy). Near Long Beach.

NAVSTA Coronado, CA 91720-5000

NAVSTA San Diego, CA 92136-5133

NSC San Diego, CA 92132 (Navy)

MCRD San Diego, CA 92140 (Navy/Marine)

NAF El Centro, CA 92243 (Navy)

NAS Miramar, CA 92145

NAVPHIBASE Coronado, CA 92155-5046

NTC San Diego, CA 92133-5000 (Navy)

NAS North Island, CA 92135-5103

NALF San Clemente, CA 92135

NAS Point Mugu, CA 93042

WPNSTA Concord, CA 94520 (Navy)

NAVCOMMSTA Stockton, CA 92503

NAVFAC Pt. Sur, CA 93920

NAVFAC Centerville Beach, Ferndale, CA 95536

NAVMEDADMINU, Monterey, CA 93943

NALF Crows Landing, CA 95313

COLORADO

Hospitals:

US Army Community Hospital, Fort Carson, CO 80913-5000. Near Colorado Springs.

10 Medical Group, USAF Academy, CO 80840-4000. Near Colorado Springs.

Medical Clinics:

21 Medical Group, Peterson AFB, CO 80914-1540. Near Colorado Springs.

821 Medical Squadron, Aurora, CO 80011-9544

CONNECTICUT

Medical Clinics:

Naval Clinic, Groton, CT 06340-5600

NAVSUBASE New London, Groton, CT 06340-5600

NAVUPWRITRAU, Windsor Locks, CT 06095. North of Hartford.

US Coast Guard Academy Health Services Clinic, New London, Groton, CT 06320

DELAWARE

Medical Clinic:

436 Medical Group, Dover AFB, DE 19902-7307

DISTRICT OF COLUMBIA

Hospital:

Walter Reed Army Medical Center, Washington, DC 20307-5000

Medical Clinics:

US Army Health Clinic, Fort McNair, Washington, DC 20319

11 Medical Group, Bolling AFB, DC 20332-0701

US Coast Guard Clinic, Headquarters, 400 7th Street, SW, Washington, DC 20024

Arlington Annex, Federal Office Bldg. No. 2, Room 1319, Washington, DC 20370 (Navy)

NAF, Washington, DC 20396-5135

NAVSECSTA, Washington, DC 20390

Naval Research Laboratory, Washington, DC 20375

Navy Yard, Washington, DC 20374-1832

FLORIDA

Hospitals:

96 Medical Group, Eglin AFB, FL 32542-1282. Near Fort Walton Beach.

6 Medical Group, MacDill AFB, FL 33621-1607. Near Tampa.

325 Medical Group, Tyndall AFB, FL 32403-5612. Near Panama City.

Naval Hospital, Pensacola, FL 32512-5300

Naval Hospital, Jacksonville, FL 32214-5600

Medical Clinics:

16 Medical Group, Hurlburt Field, FL 32544-5000. Near Fort Walton Beach.

45 Medical Group, Patrick AFB, FL 32925-3606. Near Cocoa Beach.

US Coast Guard Air Station Clinic, Clearwater, FL 33520

US Coast Guard Air Station Clinic, Opa Locka Airport, Hangar 103, Opa Locka, FL 33054

US Coast Guard Health Services Clinic, Miami Beach, FL 33139-5101

Naval Medical Clinic, Key West, FL 33040-4595

NAS Jacksonville, FL 32212

NAS Key West, FL 33040

NAVSTA Mayport, FL 32228-0148

NAS Pensacola, FL 32508

NAS Whiting Field, Milton, FL 32570

NATECHTRACEN Pensacola, FL 32511

NAVCOASTSYSCEN, Panama City, FL 32407

SOUTHCOM Health Clinic, Miami, FL (DDEAMC)

GEORGIA

Hospitals:

Dwight David Eisenhower Army Medical Center, Fort Gordon, GA 30905-5060. Near Augusta.

Martin Army Community Hospital, Fort Benning, GA 31905-6006. Near Columbus.

Winn Army Community Hospital, Fort Stewart, GA 31314-5300. Near Savannah.

347 Medical Group, Moody AFB, GA 31699-1500. Near Valdosta.

Medical Clinics:

78 Medical Group, Robins AFB, GA 31098-2227. Near Macon.

Tuttle Army Health Clinic, Hunter Army Field, Savannah, GA 31409 (Mailing address: Winn Army Community Hospital, Fort Stewart, GA 31314-5300)

US Army Health Clinic, Fort McPherson, Atlanta, GA 30330-5000 (Mailing address: Dwight David Eisenhower Army Medical Center, Fort Gordon, GA 30905-5060)

US Army Health Clinic, Fort Gillem, Forest Park (Mailing address: Dwight David Eisenhower Army Medical Center, Fort Gordon, GA 30905-5060)

US Army Troop Medical Clinic, Dahlonega (Mailing address: Martin Army Community Hospital, Fort Benning, GA 31905-6006)

Naval Medical Clinic, MCLB, Albany, GA 31705

NSCS Athens, GA 30606 (Navy)

NAS Atlanta, Marietta, GA 30060-5099

NSB Kings Bay, GA 31547 (Navy)

HAWAII

Hospitals:

Tripler Army Medical Center, HI 96859-5000. Near Honolulu.

Medical Clinics:

NAVSHIPYD Pearl Harbor, Oahu, HI 96860

NAVMAG Lualualei, Oahu, HI 96792

NAVCAMS Eastpac, Honolulu, Wahiawa, Oahu, HI 96786

MCAS Kaneohe Bay, Oahu, HI 96863 (Marine)

Westloch, Pearl Harbor, Oahu, HI 96860 (Navy)

Mental Health, Pearl Harbor, Oahu, HI 96860 (Navy)

US Army Health Clinic, Schofield Barracks, Honolulu, Oahu (Mailing address: Tripler Army Medical Center, HI 96859-5000)

US Army Troop Medical Clinic, Pohakuloa Training Area, Hilo, Hawaii (Mailing address: Tripler Army Medical Center HI 96859-5000)

US Army Troop Medical Clinic, Kilauea Military Camp, Kilauea, Kauai (Mailing address: Tripler Army Medical Center, HI 96859-5000)

15 Medical Group, Hickam AFB, HI 96853-5399

US Coast Guard Base Clinic, Honolulu, HI 96819

Naval Medical Clinic, Pearl Harbor, Oahu, HI 96860-5058

Naval Branch Medical Clinic, NAS Barbers Point, Oahu, HI 96862

IDAHO

Hospital:

366 Medical Group, Mountain Home AFB, ID 83648-5300. Southeast of Boise.

ILLINOIS

Hospitals:

375 Medical Group, Scott AFB, IL 62225-5252. Near Belleville, and the St. Louis, Mo., metro area.

Naval Hospital, Great Lakes, IL 60088-5230. Near Chicago.

Medical Clinics:

Rock Island Arsenal, Rock Island, IL 61299 (Mailing address: General Leonard Wood Army Community Hospital, Fort Leonard Wood, MO 65473-5700)

NTC Great Lakes, IL 60088 (Navy)

RTC Great Lakes, IL 60088 (Navy)

KANSAS

Hospitals:

Irwin Army Community Hospital, Fort Riley, KS 66442-5036. Near Manhattan.

Medical Clinic:

Munson Army Community Clinic, Fort Leavenworth, KS 66027-5400. Near Kansas City metro area.

22 Medical Clinic, McConnell AFB, KS 67221-5000. Near Wichita.

KENTUCKY

Hospitals:

Blanchfield Army Community Hospital, Fort Campbell, KY 42223-1498. Near Clarksville, Tenn.

Ireland Army Community Hospital, Fort Knox, KY 40121-5520. Near Louisville.

Medical Clinics:

Blue Grass Army Depot, Lexington (Mailing address: Ireland Army Community Hospital, Fort Knox, KY 40121-5520)

Blue Grass Depot Activity, Richmond (Mailing address: Ireland Army Community Hospital, Fort Knox, KY 40141-5520)

LOUISIANA

Hospitals:

Bayne-Jones Army Community Hospital, Fort Polk, LA 71459-6000. Near Leesville.

2 Medical Group, Barksdale AFB, LA 71110-2425. Near Shreveport.

Medical Clinics:

US Coast Guard Base Clinic, 4640 Urquhart St., New Orleans, LA 70117

Naval Medical Clinic, New Orleans, LA 70142-5300

MAINE

Hospital:

Uniformed Services Medical Treatment Facility, Coastal Health Services, 331 Veranda St., Portland, ME 04103

Medical Clinics:

NAS Brunswick, ME 04011-5000

NSGA Winter Harbor, ME 04693 (Navy)

NAVCOMMU Cutler, E. Machias, ME 04630

MARYLAND

Hospitals:

89 Medical Group, Andrews AFB, MD 20762-6600. Near Washington, D.C.

Uniformed Services Medical Treatment Facility, Wyman Park Health System, Inc., 3100 Wyman Park Drive, Baltimore, MD 21211

Naval Hospital, Bethesda, MD 20889-5000

Medical Clinics:

Naval Clinic, Patuxent River, MD 20670-5370

Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000

Edgewood Area, Aberdeen Proving Ground, MD (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Fort Detrick, Frederick, MD (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Kirk Army Health Clinic, Aberdeen Proving Ground (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

US Coast Guard Yard Clinic, Curtis Bay, Baltimore, MD 21226

Naval Medical Clinic, Annapolis, MD 21402-5050

NSRDC Carderock, Bethesda, MD 20084 (Navy)

NAF Andrews AFB, MD 20331-5300 (Navy)

USNA Bancroft Hall, Annapolis, MD 21402

NAVORDSTA Indian Head, MD 20640

NAVSWC White Oak, Silver Spring, MD 20910

MASSACHUSETTS

Hospital:

Uniformed Services Medical Treatment Facility, Brighton Marine Public Health Center, 77 Warren St., Boston, MA 02135

Medical Clinics:

US Coast Guard Air Station, Cape Cod Clinic Otis AFB, Falmouth, MA 02542

US Coast Guard Support Center Clinic, 427 Commercial St., Boston, MA 02188

66 Medical Group, Hanscom AFB, MA 01731-2139. Near Bedford and the Boston metro area.

MICHIGAN

Medical Clinics:

US Army Health Clinic, Selfridge Air National Guard Base, Mt. Clemens (Mailing address: General Leonard Wood Army Community Hospital, Fort Leonard Wood, MO 65473-5700)

US Coast Guard Air Station Clinic, Traverse City, MI 49684

MISSISSIPPI

Hospitals:

81 Medical Group, Keesler AFB, MS 39534-2519. Near Biloxi.

Naval Branch Hospital, Naval Home Gulfport, MS 39501-1793

Medical Clinics:

14 Medical Group, Columbus AFB, MS 39701-5300. Near Columbus.

BMC Gulfport, MS 39501 (Navy)

NAS Meridian, MS 39309-5400

Bay St. Louis, MS 39522 (Navy)

SUPSHIP Pascagoula, MS 39567 (Navy)

MISSOURI

Hospitals:

General Wood Army Community Hospital, Fort Leonard Wood, MO 65473-5700. Near St. Robert, between Lebanon and Rolla.

509 Medical Group, Whiteman AFB, MO 65305-5001. West of Sedalia.

MONTANA

Medical Clinic:

341 Medical Group, Malmstrom AFB, MT 59402-6780. Near Great Falls.

NEBRASKA

Hospital:

55 Medical Group, Offutt AFB, NE 68113-2160. Near Omaha.

NEVADA

Hospital:

99 MDG, Nellis Federal Hospital, Las Vegas, NV 89191-6001

Medical Clinic:

Naval Branch Medical Clinic, Fallon, NV 89406-5000

NEW HAMPSHIRE

Medical Clinic:

Naval Medical Clinic, Portsmouth, NH 03801-5000

NEW JERSEY

Hospitals:

Patterson Army Community Clinic, Fort Monmouth, NJ 07703-5504. Near Eatontown, south of the New York City metro area.

305 Medical Group, Fort Dix AIN, NJ 08640-5047. Near Wrightstown and Browns Mills.

Medical Clinics:

Picatinny Arsenal, Dover (Mailing address: Patterson Army Community Hospital, Fort Monmouth, NJ 07703-5504)

US Coast Guard Training Center Clinic, Cape May, NJ 08204

NAVAIRPROCEN Trenton, NJ 08628

WPNSTA Earle, Colts Neck, NJ 07722 (Navy)

NAVAIRENGCEN Lakehurst, NJ 08733-5066

NEW MEXICO

Hospitals:

27 Medical Group, Cannon AFB, NM 88103-5014. Near Clovis.

377 Medical Group, Kirtland AFB, NM 87117-5559. In Albuquerque.

49 Medical Group, Holloman AFB, NM 88330-8273. Near Alamogordo.

Medical Clinic:

McAfee Army Health Clinic, White Sands Missile Range, Las Cruces (Mailing address: William Beaumont Army Medical Center, El Paso, TX 79920-5001)

NEW YORK

Hospitals:

William L. Keller Army Community Hospital, West Point, NY 10996-1190

Uniformed Services Medical Treatment Facility, Bayley-Seton Hospital, Bay St. and Vanderbilt Ave., Staten Island, NY 10304

Medical Clinics:

Ainsworth Army Health Clinic, Fort Hamilton, Brooklyn
(Mailing address: Patterson Army Community Hospital, Fort Monmouth, NJ 07703-5504)

Watertown Arsenal, Watertown (Ft. Drum) 13602

Watervliet Arsenal, Watervliet, NY 12189

Stewart Subpost, Newburgh, NY 12550 (Army)

Fort Drum, Watertown, NY 13602-5004 (Army)

NAVUPWRTRAU, Ballston Spa, NY 12020

VA Extended Care Center, St. Albans, NY 11412

NORTH CAROLINA

Hospitals:

Womack Army Medical Center, Fort Bragg, NC 28307-5000. Near Fayetteville.

Naval Hospital, Camp Lejeune, NC 28542-5008. Near Jacksonville.

Naval Hospital, Cherry Point, NC 28533-5008. Near Havelock.

Medical Clinics:

4 Medical Group, Seymour Johnson AFB, NC 27531-2311. Near Goldsboro.

23 Medical Group, Pope AFB, NC 28302-2383. Near Fayetteville.

US Coast Guard Support Center Clinic, Elizabeth City, NC 27909

Correctional Facility, Camp Lejeune, NC 28542 (Navy/Marine)

Camp Geiger, Camp Lejeune, NC 28542 (Navy/Marine)

Rifle Range, Camp Lejeune, NC 28542 (Navy/Marine)

Camp Johnson, Camp Lejeune, NC 28542 (Navy/Marine)

French Creek, Camp Lejeune, NC 28542 (Navy/Marine)

River Road, Camp Lejeune, NC 28542 (Navy/Marine)

Physical Exam Center, Camp Lejeune, NC 28542 (Navy/Marine)

MCAS New River, Jacksonville, NC 28545 (Navy/Marine)

NORTH DAKOTA

Hospitals:

5 Medical Group, Minot AFB, ND 58705-5024. Near Minot.

319 Medical Group, Grand Forks AFB, ND 58205-6332. Near Grand Forks.

OHIO

Hospitals:

74 Medical Group, Wright-Patterson AFB, OH 45433-5529. Near Dayton.

Uniformed Services Medical Treatment Facility, Lutheran Medical Center, 2609 Franklin Blvd., Cleveland, OH 44113

Medical Clinics:

Naval Branch Medical Clinic, Defense Finance Center, 1240 E. 9th St., Cleveland, OH 44199-2055

OKLAHOMA

Hospitals:

Reynolds Army Community Hospital, Fort Sill, Lawton, OK 73503-6400

97 Medical Group, Altus AFB, OK 73523-5005. Near Altus.

72 Medical Group, Tinker AFB, OK 73145-8102. Near Oklahoma City.

Medical Clinics:

71 Medical Squadron, Vance AFB, OK 73705-5105. Near Enid.

US Army Occupational Health Clinic, McAlester Army Ammunition Plant McAlester, OK 74501

OREGON

Medical Clinics:

US Army Health Clinic, Umatilla Army Depot, Hermiston (Mailing address: Madigan Army Medical Center, Tacoma WA 98431-5021)

US Coast Guard Air Station Clinic, North Bend, OR 97459

US Coast Guard Air Station, Astoria Clinic, Warrenton, OR 97146

PENNSYLVANIA

Medical Clinics:

Dunham Army Health Clinic, Carlisle Barracks, Carlisle (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Fort Indiantown Gap, Annville (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

New Cumberland Army Depot, New Cumberland (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Letterkenny Army Depot (Mailing address: Kimbrough Army Community Clinic, Fort Meade, Odenton, MD 20755-5000)

Tobyhanna Army Depot, Tobyhanna, PA 18466

NAVAIRDEVCEN, Warminster, PA 18974

NAS Willow Grove, PA 19090

SPCC Mechanicsburg, PA 17055 (Navy)

RHODE ISLAND

Medical Clinic:

Naval Branch Medical Clinic, Newport, RI 02841-5003

SOUTH CAROLINA

Hospitals:

Moncrief Army Community Hospital, Fort Jackson, Columbia, SC 29207-5780

20 Medical Group, Shaw AFB, SC 29152-5019. Near Sumter.

Naval Hospital, Charleston, SC 29408-6900

Naval Hospital, Beaufort, SC 29902-6148

Medical Clinics:

437 Medical Group, Charleston AFB, SC 29404-4704

WPNSTA Charleston, SC 29408 (Navy)

NAVSTA Charleston, SC 29408

NAVSHIPYD Charleston, SC 29408

MCRD Parris Island, SC 29905 (Navy/Marine). Near Beaufort.

MCAS Beaufort, SC 29902 (Navy/Marine)

SOUTH DAKOTA

Hospital:

28 Medical Group, Ellsworth AFB, SD 57706-4821. Near Rapid City.

TENNESSEE

Medical Clinics:

Naval Clinic, Millington, TN 38054-5201

Naval Branch Medical Clinic, NSA Memphis, TN 38054

TEXAS

Hospitals:

William Beaumont Army Medical Center, El Paso, TX 79920-5001

Brooke Army Medical Center, Fort Sam Houston, TX 78234-6200

Darnall Army Community Hospital, Fort Hood, TX 76544-5063. Near Killeen.

59 Medical Wing, Lackland AFB, TX 78236-5300. In San Antonio.

82 Medical Group, Sheppard AFB, TX 76311-3478. Near Wichita Falls.

7 Medical Group, Dyess AFB, TX 79607-1367. Near Abilene.

47 Medical Group, Laughlin AFB, TX 78843-5244. Near Del Rio.

Uniformed Services Medical Treatment Facility, Hospital of St. John, 2050 Space Park Drive, Nassau Bay, TX 77058

Uniformed Services Medical Treatment Facilities:

St. Mary’s Hospital, 404 8th Street, N. Galveston, TX 77550

St. Mary's Hospital Family Practice Center of Port Arthur, 3600 Gates Blvd., Port Arthur, TX 77640

St. Joseph Ambulatory Care Center, 1919 La Branch, Houston, TX 77002

Medical Clinics:

Naval Clinic, Corpus Christi, TX 78419-5200

US Army Health Clinic, Red River Army Depot, Texarkana (Mailing address: Darnall Army Community Hospital, Fort Hood, TX 76544-5063)

70 Medical Squadron, Brooks AFB, TX 78235-5336. Near San Antonio.

17 Medical Group, Goodfellow AFB, TX 76908-4902. Near San Angelo.

76 Medical Group, Kelly AFB, TX 78241-5846. In San Antonio.

12 Medical Group, Randolph AFB, TX 78150-4801. Near San Antonio.

NAS Kingsville, TX 78364

NAS Dallas, TX 75211-9516

UTAH

Hospital:

75 Medical Group, Hill AFB, UT 84056-5012. Near Ogden.

Medical Clinics:

Dugway Proving Ground, Dugway (Mailing address: Fort Carson, CO 80913)

Tooele Army Depot, Tooele (Mailing address: Fort Carson, CO 80913)

VIRGINIA

Hospitals:

1 Medical Group, Langley AFB, VA 23665-2080. Near Hampton.

Dewitt Army Hospital, Fort Belvoir, VA 22060-5166. Near Alexandria.

McDonald Army Community Hospital, Fort Eustis, VA 23604-5567. Near Newport News.

Naval Medical Center, Portsmouth, VA 23708-5000

Medical Clinics:

Andrew Rader US Army Health Clinic, Fort Myer, VA 22211. Near Arlington.

Arlington Hall Station, Arlington (Mailing address: Walter Reed Army Medical Center, Washington, DC 20307-5000)

Davison US Army Airfield, Accotink (Mailing address: Dewitt Army Hospital, Fort Belvoir, VA 22060-5166)

Fort A.P. Hill, Bowling Green (Mailing address: Dewitt Army Hospital, Fort Belvoir, VA 22060-5166)

Kenner Army Clinic, Fort Lee, VA 23801-5260. Near Petersburg.

Fort Monroe, Hampton (Mailing address: McDonald Army Hospital, Fort Eustis, VA 23604-5567)

Fort Story, Virginia Beach (Mailing address: McDonald Army Hospital, Fort Eustis, VA 23604-5567)

US Coast Guard Support Center Clinic, Churchland, Portsmouth, VA 23703

US Coast Guard Reserve Training Center Clinic, Yorktown, VA 23690

Navy Medical Clinic, Quantico, VA 22134-6050

Navy Medical Clinic, Norfolk, VA 23508

Navy Branch Clinic, Arlington Annex, Arlington, VA 20370

NAVSWC Dahlgren, VA 22448-5000

CGMCDEC Mann Hall, Quantico, VA 22134 (Navy)

OCS Camp Upshur, Quantico, VA 22134 (Navy/Marine)

Brown Field, Quantico, VA 22134 (Navy/Marine)

TBS Quantico, VA 22134 (Navy/Marine)

Sewells Point Clinic, NAVSTA, Norfolk, VA 23511

ARF Dispensary, NAS Norfolk, VA 23511

Naval Shipyard, Norfolk, VA 23511

NAVPHIBASE Little Creek, VA 23521

NSC Warehouse Dispensary Norfolk, VA 23512

Dam Neck Base, Virginia Beach, VA 23461-5200 (Navy)

NAVSHIPYD Portsmouth, VA 23709

WPNSTA Yorktown, VA 23691-5021 (Navy)

NAS Oceana, VA 23246. Near Virginia Beach.

Lafayette River, Norfolk, VA 23508-1299 (Navy)

De-Gaussing Facility, Lambert's Point, Norfolk, VA 23511 (Navy)

NSC Dam Neck, Norfolk, VA 23512 (Navy)

NALF Fentress, Chesapeake, VA 23460-5120 (Navy)

NAVRADSTA, Northwest Chesapeake, VA 23322

HSA CINCLANTFLT, Norfolk, VA 23511 (Navy)

WASHINGTON

Hospitals:

Madigan Army Medical Center, Tacoma, WA 98431-5021

Naval Hospital, Oak Harbor, WA 98278-8800

Naval Hospital, Bremerton, WA 98312-1898

Uniformed Services Medical Treatment Facility, 1131 14th Ave. South, Seattle, WA 98114

Medical Clinics:

92 Medical Group, Fairchild AFB, WA 99011-8704. Near Spokane.

62 Medical Group, McChord AFB, WA 98438-1130. Near Tacoma.

US Coast Guard Air Station Clinic, Port Angeles, WA 98362

US Coast Guard, 1519 Alaskan Way South, Seattle, WA 98134

Naval Medical Clinic, NAVSTA, Seattle, WA 98115-5004

NAVSHIPYD Bremerton, WA 98314

NAVSTA Everett, WA 98207-1300

NAVSUBASE Bangor, WA 98315-5720

NAVUSEAWARENGSTA Keyport, WA 98345

NUSWNGSTA Indian Head Det Hadlock, WA 98339

WEST VIRGINIA

Medical Clinics:

Naval Branch Medical Clinic NAVRADSTA, Sugar Grove, WV 26815

WYOMING

Hospital:

90 Medical Group, F.E. Warren AFB, WY 82005-3913. Near Cheyenne.

PUERTO RICO

Hospital:

US Naval Hospital, Roosevelt Roads, FPO AA 34051-8100

Medical Clinics:

US Army Health Clinic, Fort Buchanan, San Juan, PR 00934

US Coast Guard Air Station Clinic, Aquadilla, PR 00604

US NAVSECGRUACT, Sabana Seca, FPO AA 34053

Vieques, FPO AA 34053

MEDICAL FACILITIES OVERSEAS

ANTIGUA

Naval Branch Medical Clinic, USNAF Antigua, FPO AA 34054

AZORES

65 Medical Group (Lajes), APO AE 09720-5300

BAHRAIN

Naval Branch Medical Clinic, Administrative Support Unit
Bahrain, FPO AE 09834

BELGIUM

SHAPE Health Care Facility, APO AE 09705

CUBA

Hospital:

US Naval Hospital, Guantanamo Bay, FPO AE 09593-0136

Medical Clinics:

USNAVSTA Guantanamo Bay, FPO AE 09593

Leeward USNAS, Guantanamo Bay, FPO AE 09593

FEDERAL REPUBLIC OF GERMANY

Hospitals:

US Army Hospital—Heidelberg, APO AE 09102

US Army Hospital—Wurzberg, APO AE 09244

Landstuhl Regional Medical Center (Kaiserslautern) APO AE 09180

52 Medical Group (Bitberg/Spangdalem), APO AE 09126-3690

Medical Clinics:

US Army Health Clinics:

Babenhausen, APO AE 09089

Bad Aibling, APO AE 09098

Bad Kreuznach, APO AE 09252

Bamberg, APO AE 09139

Baumholder, APO AE 09034

Buedingen, APO AE 09076

Butzbach, APO AE 09045

Darmstadt, APO AE 09175

Dexheim, APO AE 09111

Fiedberg, APO AE 09074

Giebelstadt, APO AE 09182

Grafenwoehr, APO AE 09114

Hanau, APO AE 09165

Hohenfels, APO AE 09173

Ilesheim, APO AE 09264

Katterbach, APO AE 09250

Kitzingen, APO AE 09031

Mannheim, APO AE 09166

Sandhofen, APO AE 09028

Schweinfurt, APO AE 09033

Wiesbaden, APO AE 09096

USAF Clinics:

470 Medical Flight (Geilenkirchen), APO AE 09104-8030

86 Medical Group (Ramstein), APO AE 09094-3215

469 Medical Flight (Rhein-Main), APO AE 09050-8490

US Navy Medical Clinics:

Detachment Landstuhl, Landstuhl Army Medical Center, 2nd General Hospital, APO AE 09180

Detachment Wiesbaden, USAF Lindsey Air Station, USAF Regional Medical Center, APO AE 09220-5300

GREECE

Medical Clinic:

Naval Branch Medical Clinic, USNAVSUPPFAC Souda Bay, Crete, FPO AE 09847

GUAM

Hospital:

US Naval Hospital Guam, FPO AP 96630-1600

Medical Clinics:

USNAS Guam, FPO AP 96630

USNAVMAG Guam, FPO AP 96630

USNAVSTA Guam, FPO AP 96630

NAVCAMS West Pac, Guam, FPO AP 96630

Occupational Health, USNAVSTA Guam, FPO AP 96630

36 Medical Group, Anderson AFB Guam, APO AP 96543-4010

ICELAND

US Naval Hospital Keflavik, FPO AE 09728-0308

ITALY

Hospitals:

US Naval Hospital Naples, P.O. Box 19, FPO AE 09619-0070

US Naval Branch Hospital, USNAF Sigonella, Sicily, FPO AE 09627-2500

Medical Clinics:

US Army Health Clinic, Camp Darby, Livorno, APO AE 09613

US Army Health Clinic, Livorno, APO AE 09613

US Army Health Clinic, Vicenza, APO AE 09630

31 Medical Group, Aviano AFB, Italy APO AE 09601-0245

USNAVSUPPACT Det, Gaeta (Mailing address: Commander, Naval Medical Command, European Region, P.O. Box 22, FPO AE 09499)

USNAVSUPPO LaMaddelena, Sardinia (Mailing address: Commander, Naval Medical Command, European Region, P.O. Box 22, FPO AE 09499)

JAPAN

Hospitals:

35 Medical Group (Misawa), APO AP 96319-5024

374 Medical Group (Yokota), APO AP 96328-5000

Naval Hospital, Okinawa, FPO AP 96362-1600

Naval Hospital, Yokosuka, FPO AP 96350-1615

Medical Clinics:

US Army Health Clinic, Camp Zama (Mailing address: US Army Medical Dept. Activity, Japan APO AP 96338-5011)

US Naval Branch Medical Clinic Atsugi, U.S. Naval Facility Box 2, FPO AP 96306-1600

COMFLEACT Sasebo, FPO AP 96322

Kamiseya, FPO AP 98768

18 Medical Group (Kadena) APO AP 96368-5268

Naval Branch Medical Clinic, Iwakuni, PSC 961, Box 1877, FPO AP 96310-1877

KOREA

Hospitals:

US Army Hospital, Seoul, APO AP 96301-0080

8 Medical Group (Kunsan), APO AP 96264-5300

51 Medical Group (Osan), APO AP 96278-5300

Medical Clinics:

US Army Health Clinic, Pusan, APO AP 96259-0257

US Army Health Clinic, Wongiu, APO AP 96397

US Army Health Clinic, Yongsan, APO AP 96301

US Army Health Clinic, Taegu, APO AP 96218

51st Medical Group—OLB (Suwon AB), APO AP 96461

51st Medical Group—OLB (Taegu AB), APO AP 96213

PANAMA

Hospital:

24 Medical Group (Howard AFB), APO AA 34001-5300

SAUDI ARABIA

US Army Health Clinic, Dha Hran, APO AE 09808

SPAIN

US Naval Hospital, Rota, FPO AE 09645-2500

TURKEY

Hospital:

39 Medical Group (Incirlik), APO AE 09824-5000

UNITED KINGDOM

Hospital:

48 Medical Group (Lakenheath), APO AE 09464-0230

Medical Clinics:

423 Med Flight (Upwood), APO AE 09470

USNAVFAC Brawdy, APO AE 09420

US Naval Medical Clinic, London, FPO AE 09499

603 CS/Medical Aid Station (RAF Croughton, UK), APO AE 09494

US Naval Branch Clinic, St. Mawgan, FPO AE 09409-1006

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